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THE NATIONAL, STATE, AND LOCAL TUBERCULOSIS ASSOCIATIONS OF THE UNITED STATES

The Wisconsin Medical Journal

Volume XXVI | Milwaukee, January, 1927 | Number 1

Etiology and Treatment of Nephritis and Hypertension*

BY JOSEPH MILLER, M.D.
Chicago

If I can say anything to inspire discussion I shall be glad to spend as much time answering questions as you may wish.

Here is a patient who has been in the University Hospital for several months. He is a Greek, now thirty-three years of age, by occupation a candy-maker. He always has been a candy-maker.

He has never had any acute illness except an acute arthritis in 1916. He was in bed a considerable time, apparently suffering no heart inconvenience from it, because he was able to do all sorts of vigorous exercise after that. He shows at the present time no heart lesion. He thought he was in good health until October, 1925, when one day while at work his right arm became numb and then weak, and in a few minutes his leg gave way; he fell over and became unconscious and had a right-sided hemiplegia. He has improved. He has had massage, manipulation, and while we ordinarily say that in hemiplegia a maximum amount of improvement takes place in six months, where the patient has massage and manipulation and is educated how to manipulate the extremities, he may continue to improve for a long time. This patient is still improving, is able to walk now, without a cane.

He did not come into the hospital right at the time this occurred. When he came into the hospital they found, upon examining him, besides his right-sided paralysis that he had a blood pressure of 233 systolic with 150 diastolic. The rest of the physical examination, outside of the hemiplegia, was quite negative. He had no heart murmur; he had a moderately hypertrophied heart which you find in such patients. At times when the urine was examined it showed nothing; at other times it showed perhaps a trace of albumin; at other times it showed quite a number of hyaline and granular casts. Dr. Middleton says he shows recurrent showers of casts.

All functional tests are normal. His blood chemistry is normal, and the phenolsulphonephthalein test is also normal; that is, as far as we can tell by functional tests this man has a normal functioning kidney. But he does have a high blood pressure.

First of all we ask ourselves, has this man really a nephritis? We know he has a hypertension. Has he really a nephritis? I think we may say now that with these showers of casts which he has he probably does have a nephritis, probably he has changes in the kidney. This question comes up, then: Is his nephritis the cause of his hypertension? I feel quite certain that this man has had hypertension for a number of years. We don't get a systolic of 230 in a few months. If we had seen this man early when his hypertension was not so marked, I think we would have found that his urine showed nothing abnormal. In the ordinary hypertension case, seen early, you will find the urine does not show anything abnormal, and after years go by and as the hypertension progresses, eventually most of these patients reach a point where we find evidence of kidney involvement, that is the presence of casts. Rather rarely, however, do any of these hypertension cases show evidence of impaired renal function; that is, the renal function remains good, and rather rarely do these people succomb to a uremia. The cause of fatal termination in these cases is either a cerebral hemorrhage or a broken compensation.

I think while at the present time we would say this man has some kidney changes, some nephritis, the nephritis has probably developed as a result of the hypertension, or accompanied the hypertension and was not the cause.

PRIMARY ORIGIN

We formerly believed and taught that all hypertension was associated with kidney changes. The tendency now is to look upon most hypertension

*Clinical discussion before 85th Anniversary Meeting, State Medical Society of Wisconsin, Madison, Sept., 1926.

cases as being what we call primary, that is they come first, and as time goes by, either as a result of the vascular changes, which are secondary to the hypertension, or as a result of the same agent, whatever that may be, that causes the hypertension, sooner or later kidney changes appear.

I think we would call this man a primary hypertension, and perhaps we would add that now he has some kidney changes, but I do not think we would say this man in the beginning had a Bright's disease which caused this hypertension. The hypertension came first, the kidney changes second. That is true of the vast majority of cases with hypertension; they are primary hypertensions. If you happen to get them late, you are apt to find evidences in the urine of kidney disease. If you get them early, you won't find them.

What is the etiology of the man's hypertension, assuming that it was not a primary kidney? Here is a man only thirty-three years of age; he has had no serious illnesses, barring acute arthritis, which apparently did not cause any damage. He had no symptoms until this came on. He had no shortness of breath; he gave no history of any infections; he has not had sore throat; he does not give a history of anything special. He has been a man with good health. He says he gets to bed at a reasonable hour. He has worked pretty hard and has used alcohol very moderately; he smokes rather excessively. In this man, as in most of these cases, we have nothing at all to which to trace the hypertension. What does it come from? There have been a good many attempts at explaining causes of hypertension, none of which, however, is in any way satisfactory or in any way proven. Excessive meat eating has been given as one. We have no evidence today that excessive meat eating ever brought on hypertension. Constipation is another. It is quite possible that that may be a factor. Overwork, hard work, is a possible factor. Focal infection has been suggested but without presenting adequate evidence.

From the days of Hippocrates to the present time the medical profession has always had to have a fad. For 2,000 years bleeding for practically everything was in vogue; up to the middle of the eighteenth century people were bled for everything. Then along about the sixteenth century there was a fad of antimony for everything. Inasmuch as antimony was a very dangerous drug, the French government passed a law that the doctors could not prescribe it because they were killing so many people.

When I was a medical student, when we didn't know just what was the matter with a patient or when we knew what was the matter with him but didn't know what caused that trouble, we said he had a uric acid diathesis, and felt very comfortable about it. Then as time went by we had our fad of vaccine therapy, which is now just about on its last legs.

At the present time, we have a couple of fads which promise to run the same course as those in the past. When we have a patient and can't say just what is the matter with him, or if we are a little lazy and don't want to spend a lot of time finding out what is the matter wih him, we either say he has an endocrine disturbance or that he ought to have his teeth pulled. If we have a disease that is a little obscure, (we have lots of diseases we don't know the etiology of) we say it is due to focal infection, and focal infection has to fill the bill just as uric acid diathesis had to fill the bill years ago. Some claim that hypertension is due to endocrine disturbance. As a matter of fact, we don't know the cause.

There are some theories as to what happens. The belief at the present time is that vascular spasm is responsible for the hypertension; the thickening of the vessels is a secondary affair as a protective matter to strengthen the vessel walls, but then we come back to the question, what causes this vessel spasm? That we don't know.

There are some interesting possibilities. In the end products of digestion of protein the amino-acids are formed. It is in that form that the proteins are absorbed. There are some amino-acids which have the ability to raise blood pressure. Tyramin is one; it has an effect very much like adrenalin. Guanadin is another. It has been the hope of some that we may find in a study of these so-called pressure amines, the substance which is responsible for the vascular spasm. If we want to theorize a little bit, we can do it with these things. We can say that the tyramin is this substance, (it is all hypothetical) that tyramin is eliminated through the kidney with great difficulty, that very mild impairment of the kidney which will let the urea and creatinin and uric acid through may hold back the tyramin, and eventually the tyramin accumulates in the blood until it reaches a point where it causes vascular spasm. With such

a theory the kidney would be back of it after all.

At the present time we have no way of determining the amount of tyramin in the blood or no method of determining the amount of guanadin, but these are the clues being followed now to see whether these amines, the end products of digestion, are factors in causing vascular spasm.

A KNOWN CAUSE

I think we should be a little loath to abandon at once the idea that the kidney is not concerned, because the one known cause of hypertension is an acute nephritis. When we see an acute nephritis, and observe the pressure go up in the course of a week or ten days, we feel quite certain that back of that particular blood pressure the kidney is certainly concerned. So I think we should be a little loath to discard the kidney as a factor. But if the kidney is a factor, the impairment in the kidney early is so slight that it cannot be detected clinically nor can it be detected histologically. It may still be, however, a kidney that does not function properly for certain things.

This man had his hemiplegia during the daytime. We know that very frequently people have hemiplegia in the night. It is a very common thing, and it is quite generally believed, and probably true, that at night our pressure goes down. It has been shown that after a person gets to sleep his pressure goes down gradually to a certain level, and a half hour before he awakens it starts to go up, so we would think with a lower blood pressure at night people should not have hemiplegia as often as they do during the hours of sleep.

An Englishman has come along with some very interesting observations. He has studied the effect of dreams on blood pressure, and by a device which he has been able to demonstrate that a bad dream will raise a patient's blood pressure thirty or forty millimeters, so it is possible that these hemiplegias that occur by night may be due to a high blood pressure from a bad dream.

If we could have seen this patient two or three years ago, could we have done anything to prevent what has happened? I doubt it. First, we have no means of preventing blood pressure, and I don't think we will have until we find out its cause. Can we cure high blood pressure? I take off my hat to the doctor who can cure high blood pressure: I never have been able to do it. But I have seen patients not infrequently who have told me that some friend is being treated by a certain method, either diathermy or intravenous injection, etc., and has been cured of a high pressure. I always insist that those patients go and take this treatment, only asking that when they are cured they come back so that I may compare the pressure with their average pressure during the period I observed them. It has always resulted the same way: an optimistic patient comes into the office saying he is feeling fine, and his blood pressure is just exactly the same as it was before.

I do not mean to say that the person who treats those patients is dishonest. But I think he has failed to take cognizance of the extreme variations in blood pressure in these hypertension patients when you don't do anything; I mean their blood pressure fluctuates tremendously.

A few months ago we took twenty-five records of hypertension from our office files, without selection except to take patients who had had in the course of three or more years at least five readings at different times. We found that of the twenty-five patients eighteen showed a variation of pressure between the maximum and minimum of between forty and fifty millimeters; it fluctuated that much. If you fail to take cognizance of what happens to the blood pressure in these people, how they do go up and down, you may think you are accomplishing something when you are not.

When a doctor tells me that a patient had his tonsils out yesterday and this morning his blood pressure is thirty points lower than it was the day before, I conclude that man probably had a fair night's sleep, or else he was so scared before having his tonsils removed that his pressure was unusually high.

Of these twenty-five patients, twenty-three had the highest pressure on the first visit, the first time it was taken at the office, which I think was solely due to going to someone whom they didn't know, and the little excitement and tenseness associated with a first visit.

REST

There has been considerable work done on the modification of blood pressure by rest. Mosenthal who has done a good deal of work on the kidney, took fifty patients with hypertension and tried the effect of rest. He had them lie down, and took their pressure every five minutes. He found that there were eighteen of these patients in from ten to twenty minutes had a lowering of the blood

pressure of twenty-three millimeters or more, just by resting.

This is of interest from several standpoints. If we are going to test out the effect of any agent on blood pressure, we must first get a series of observations on that patient, extending, I should think, over two or three months with perhaps five or six or seven readings to find out the normal variation. Then when we try this agent, whatever it may be, we must let the patient live just the same as he lived during the control period. If we put him to bed and start this method of treatment on him, the fact that he is in bed may account for the pressure going down, but if we want to do it accurately we must let him live in the same manner as he did in this control period when we took his pressure. I believe if we do that we will find that we have nothing which has any lasting effect on blood pressure.

To show how easily pressure is modified by intenseness, if a man is playing a game of cards it apparently does not make much difference whether he wins or loses; his blood pressure may rise twenty-five or thirty points. This effect of tenseness or excitement on blood pressure is of a good deal of interest, I think, when we come to treating the patients.

Now if this patient had come to us two or three years ago, we probably would have told him to avoid overwork, not to make his hours too long, to see that he got seven or eight hours' sleep. We would find out, by questioning the patient, that he did have a very severe worry for many months before this came on. I think possibly it may have been a factor in raising his blood pressure to these high peaks, thus accounting for the hemiplegia coming on.

When a patient comes to me with high blood pressure, I first try to find out exactly his manner of living, whether he works unusual hours, whether he has any recreation, whether he is a great worrier, and I try to instruct him, or tell him, that of all the things we do in the treatment of hypertension we believe relief from tension, worry, excitement, probably holds first place, that he should try to educate himself not to get angry, to try not to be annoyed, to unload, if he can, part of his business burden, if it is very heavy, on to other shoulders; he should see that he gets his vacation, he should spend his nights at home, not out playing poker or bridge or carousing about.

DIET

Then comes the question, what about diet in these hypertension cases. We have no evidence that meat has anything to do with it. This man is a good example of advanced hypertension with a normal functioning kidney. He has no nitrogen retention.

I think it is a real hardship on these people to take them off of meat unless there is some reason for it. First of all, every time they sit down to the table they are reminded of the fact that there is something the matter with them, that they cannot have what everybody else has. To get out of the man's mind a study of himself is a very important thing. I usually tell him to take bacon and eggs at breakfast and meat of any other kind at one other meal. We have no reason to believe there is any difference between chicken and roast beef. I wouldn't let him eat excessively of meat, but I would give him bacon and eggs at breakfast and meat at one other meal.

The question of coffee arises. I mention this because I do not think we ought to withdraw from this person who is already unhappy because he has a high blood pressure anything that will add to his unhappiness. I always say he can have coffee for breakfast. He doesn't need to have postum. Perhaps at another meal he can take a little weak coffee, but it is the breakfast coffee he misses most.

Smoking. Dr. Middleton told me that he felt rather suspicious about that. I wouldn't speak very strongly against smoking in these cases. We have no evidence that smoking makes any difference in blood pressure or has anything to do with it. In fact, we have no evidence that smoking does very much damage. We have abundant evidence as to what damage liquor does. There are some people, of course, who are susceptible to nicotine and get cardiac disturbances from it.

If these people are cigar smokers, I tell them they can smoke a cigar after meals, and if they look very much disappointed I sometimes tell them they can have two after meals, but they should not smoke all the time.

What about water in these patients? I think it is safe in any kind of nephritis never to let the patient suffer from thirst. I think patients with edema should not suffer from thirst. If they had edema they should restrict their fluids to the point where they are satisfied.

There was a belief that excessive water drinking

raised blood pressure. Excessive water drinking does not raise blood pressure. We tested a series of five patients with high blood pressure to see if there was anything to this theory. We put a Rehfuss tube in and poured down two and a half quarts of water, and every two and a half hours we repeated it, so they got ten quarts in a day. We took the pressure, and after the first two and a half quarts there was absolutely no change in the blood pressure, but as we went on they did get a good deal of change before night. I am quite sure no one can drink enough fluid to affect the blood pressure. It is true that as we increase the amount of urine up to a certain point, about two quarts, the amount of nitrogenous waste gotten rid of increases; I mean we do get a little better elimination from the kidney as we run the urinary fluid at least up to about two quarts a day; beyond that there is no apparent increase in the urinary constituent.

SODIUM CHLORID

Another question is that of sodium chlorid. Dr. Allen several years ago advanced the view that sodium chlorid was a factor in hypertension. He put his patients on an exceedingly low sodium chlorid diet and claimed to get improvement. As far as I know, no one except Allen's immediate associates ever have been able to confirm these findings. It has been worked out quite carefully, and I think we can safely say there is no evidence that sodium chlorid plays a role in hypertension. It is true that if you put a patient on an exceedingly low sodium chlorid diet he doesn't like the food, he quits eating and becomes under-nourished, and when one of these patients gets under-nourished and thin the pressure does go down, but it does not mean the patient is better. I do not believe it is necessary to inconvenience these patients by cutting out their salt. Perhaps we ought to be a little careful about excessive salt, salt meats, and things like that, but I think we are adding another inconvenience to the patient's daily routine by cutting out his salt, at least with the knowledge we now have in regard to sodium chlorid and high blood pressure.

NEPHRITIS

I was expected to discuss the question of nephritis here, and I might say just a few words about it. The question arises, first, as to what we are to do about these various classifications which we have seen during the last few years.

I think the classifications of nephritis have chiefly led to confusion, because if you try to fit patients into them you find a lot who don't fit, they belong in two or three of the groups.

I believe practically all of us who practice medicine probably can be content when we say a patient has an acute nephritis or a chronic nephritis, or, if you want to say he has an acute Bright's disease or a chronic Bright's disease, it seems to me that is a perfectly good term. The effort to classify these chronic forms into different groups just leads to confusion. A few of them you can put into those groups; a lot of them are mixtures that don't fit anywhere.

I think acute nephritis in adults is a rare disease; I very seldom see it. Acute nephritis in children is very common. A good deal of work has been done on that recently by Marriott of St. Louis and others, and they all seem to lay stress on the point that most cases of acute nephritis in children are of upper respiratory tract origin, tonsils, adenoids, or sinuses; they particularly emphasize the sinuses. Many of these children do not complain of sinuses, and I think we might emphasize the fact that in an acute nephritis in a child where apparently the tonsils or adenoids are not responsible, or even if they appear responsible, we should not drop the search until there has been a transillumination of the antrum to make sure there is not an infection that is causing the trouble, because if there is, washing out of the antrum will cause the nephritis to disappear very promptly.

I think we can say that in children adenoids, tonsils, sinuses, are the chief sources of the infection responsible for acute nephritis. This field should be more thoroughly explored in case we are in doubt as to the origin.

What can we do with anuria when we have that in acute nephritis? That is a very discouraging problem. In a patient with anuria none of the diuretics will work. Diuretin and various caffein preparations will not work. On the other hand, in edema of cardiac origin, diuretin, theocin, novasurol, will act; in kidney involvement, no. When the kidney stops secreting you cannot start it until it is ready to start. If these patients do not have edema, I wouldn't hesitate to push the water for a number of hours until you feel you may be getting danger. In edema, restriction of water to what they need is best.

There is one agent that I think is worth while

trying in these patients with anuria, and that is the intravenous injection of a ten or twenty per cent glucose. We have been very much interested in that largely through Dr. Woodyatt's work, and I certainly have seen a few cases of anuria where after the injection of 250 c.c. of a twenty per cent glucose the patient would pass perhaps a pint or a pint and a half in the next four or five hours, and then stop; another glucose injection and again you would get an output of urine for a few hours. This is supposed to attract the fluid from the tissues into the blood current, and edema is partly due to the attraction of the tissues for the fluid.

I am glad to say that this man here has all his teeth and he has his tonsils. They haven't pulled his teeth or removed the tonsils.

I never see a chronic arthritis that hasn't usually the tonsils and most of the teeth out, and some of those unfortunate individuals can't wear a plate and they are rather up against it, especially if they are old. Recently a large percentage of the patients I have seen with hypertension have had their teeth pulled. I think this is really a serious matter. When we look around to see what evidence is back of this, we find that the evidence does not come from the clinician but from the laboratory. The laboratory man takes a pulpless tooth, gets a culture from it, takes five cubic centimeters of this beef tea culture and injects it into a rabbit of 1,500 grams, which would be the same as injecting into you or me two and two-thirds ounces of a beef tea culture, and then because something happens to the rabbit he immediately concludes that such a tooth was a menace to the patient. Even with a root abscess a patient should not be told that if he gets that tooth out he is going to be well of anything. I don't mean it ought to be left in. I tell the patient he can get the tooth out but I don't believe it is going to affect him one way or the other. Those root abscesses may have been there for a long time, and those imprisoned bacteria have almost certainly lost a lot of their virulence and the individual has acquired an immunity to them. It doesn't seem logical to conclude that something is happening to the patient just because you take an enormous amount of infected material and inject it into a non-immune rabbit. This can only be settled by the clinician and his careful observations of what happens.

Before we make observations we must be familiar with the course of untreated disease and we must be familiar with the psychology of the sick. The chronic invalid is just waiting for somebody to wave the magic wand that will cure him. If you can only make that person believe that something is going to cure him, he is going to come back in a few days or months and tell you he is cured. He is not a bit better than before except that he thinks he is. The psychology of the chronic invalid is something we must always take into consideration in any therapeutic measures.

The second thing we must always take into consideration is the course of the untreated disease. Until we know the course of the untreated disease we are not in position to draw conclusions from that particular disease when treated.

See page 18 for group discussion.

Prognosis in Chronic Hypertonia*

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It is usually conceded that the cause and mechanism of chronic hypertension are unknown, and that the different clinical types are not always clearly separable. Yet it is generally understood that there is a type of chronic hypertension associated with, and probably secondary to, chronic glomerular nephritis, and, that there is another type associated with a diffuse sclerosis of the smallest arterioles and their parent arteries, whose relationship to kidney and small vessel disease is not definitely known. The first type may be called nephritic hypertension; the second type, vascular hypertension. Essential, primary or benign hypertension are names also used for this latter condition. The term diffuse hyperplastic sclerosis is used here to distinguish this disease of the smallest arterioles from the senile or decresent type of arteriosclerosis where the large peripheral vessels are hardened, and as a rule not associated with hypertension. Concerning vascular hypertension and its relationship to blood vessel disease, there has been considerable discussion. The diffuse sclerosis of the small arterioles constantly

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seen in this type of hypertension are originally described by Gull and Sutton[1]. Their extensive studies were carried out with the object to determine the relationship between hypertrophy of the heart without valvular lesion, and renal disease. They described a hyalin-fibroid change around the small arteries, arterioles and capillaries and called it arterio-capillary-fibrosis. They concluded that this arterio-capillary-fibrosis tended to increase peripheral resistance which raised arterial tension that resulted in hypertrophy of the heart.

Councilman[2] later described this disease of the small arteries and arterioles and called it diffuse arteriosclerosis. He emphasized that the media and intima of the small vessels underwent hyaline and fatty degeneration followed by atrophy and sclerosis. Recently Evans[3] made a more elaborate histological examination of the vessels from such cases of arteriosclerosis and preferred to call it diffuse hyperplastic sclerosis. Evans claimed the essential lesion was a thickening of the intima in the smaller and smallest arteries. The process begins with a proliferation of the endothelial cells, followed by fatty degeneration of these cells and finally complete degeneration with blocking of the lumen of the vessel. He holds that the clinical expression of this disease is hypertrophy of the heart and hypertension. That diffuse hyperplastic sclerosis and hypertrophy of heart are the simultaneous results of the action of a common cause is his view. Janeway[4] analyzed a large group of histories of persons with high blood pressure to determine if a relationship existed between the symptoms and objective findings and subsequent course of the disease on which a more exact prognosis might be based. He designated all chronic hypertension cases hypertensive-cardiovascular disease, either primary, or secondary when preceded by an inflammatory nephritis. He emphasized that many cases of hypertension showed very little, if any, renal change, but an extensive arteriolar disease. He believed that it was impossible to foretell what the changes in the kidney will be and that combination of nephritis and arteriolar sclerosis may be seen. He added that further work with renal function tests might be of value in differentiating one from the other. The height of the blood pressure did not seem to have much bearing on the expectancy of life. A considerable number lived for a long time and this suggests the need of caution in making a prognosis as to expectancy of life.

Fishberg[5] found that of eighty-two cases of chronic hypertension coming to autopsy, seventy-two or eighty-eight per cent were instances of essential hypertension. All cases showed more or less marked, but always clearly defined arteriolar lesions. In every instance the minute arterioles of the kidney were affected. The arteriolar lesions were found most often in the kidney, spleen, and pancreas, while the arterioles of the skin, skeletal muscles, lungs and gastro-intestinal tract were seldom involved. Five of the seventy-two cases, or seven per cent, died with renal insufficiency; the majority of them died of cerebral hemorrhage or heart failure. In speaking of the type of disease under discussion, Bell and Hartzell,[6] after dividing arteriosclerosis of the kidney into (a) the senile type and (b) the hypertension type, add the following: "In many cases of chronic hypertension, normal kidneys are found at necropsy and in some a glomerulonephritis is found; but a large percentage of cases are associated with disease of the renal arteries. When no disturbance of renal function is demonstrable, we speak of essential hypertension, but when there is evidence of serious renal injury, we consider the condition chronic Bright's disease. The kidneys from cases of essential hypertension usually show hyaline degeneration of some of the afferent glomerular arteries and often there is also disease of the medium sized and small arteries and there are gradual transitions between the slight involvement of the arteries in these cases and the extensive involvement in chronic Bright's disease of the vascular type. The majority of patients with

	Diffuse Hyperplastic Sclerosis	Chronic Nephritis
1. Urine analysis	Albumin trace, few if any casts, very few blood elements.	Albumin 3, many granular casts and blood cells
2. P. S. P.	45—60 per cent	10 per cent
3. Blood urea nitrogen	18—25 mg. per cent	35—80 mg. per cent
4. Urea concentration factor of McLean	45—60	10—20

essential hypertension die of cardiac or cerebral complications without developing serious renal involvement, but in some cases extensive destruction of renal tissue occurs and they are then regarded as being cases of chronic Bright's disease of the arteriosclerotic type." There are about twenty-six examples of this form of Bright's disease in a series of thirty-three hundred necropsies.

Moschcowitz[7] believes that there is no indication for a division of chronic hypertension into essential, arteriosclerotic and nephritic groups because, he says, the vast majority of disorders associated with persistent hypertension begin as "essential" hypertension, which, if untreated, lead to the clinical concepts of arteriosclerotic, nephritic and other hypertensions.

After thoroughly studying the question of relationship of arteriosclerosis to hypertension, Ophuls[8] concludes that the exact relation is not known, but suggests that both may result from the effect of bacterial toxins on the blood vessels, which, according to circumstances, may at times produce more of a functional and other times more of an anatomic effect or both simultaneously.

In a broad way these two groups, the nephritic and the vascular, cover the majority of cases of chronic hypertension. Since high blood pressure has become, in the minds of some, synonymous with apoplexy and Bright's disease, it is essential for correct prognosis to emphasize that the outcome of patients in these two groups differs immensely. When hypertension is associated with a recognizable renal insufficiency the significance of the hypertension takes on a serious outlook, while the hypertension that exists separately from renal insufficiency may run a long course with little or no inconvenience to the patient for many years.

A THIRD CLASSIFICATION

To these two groups we add a third which seems to have characteristics differing from the other two. We call this the arteriosclerotic group. It is difficult at times to decide whether in women past the menopause the hypertension belongs in the menopausal hypertension class or whether it is in our arteriosclerotic class. Certain features characterize these three groups yet one must not gather the impression that these types are fixed or that it is always possible to place any individual cases in one group. There are gradations between the groups particularly between the cases of essential hypertension which later show kidney changes and the chronic glomerular group on the one hand, and gradations between the essential hypertension and arteriosclerotic group on the other hand.

The differentiation between the nephritic and vascular types may be at times difficult, and at other times easy. In the former variety there is often a history of infection associated with nephritic symptoms, followed by a period, of several years or more, of quiescence, with a subsequent persistent hypertension and renal insufficiency. In this group of cases the patients are usually younger and the urine contains more albumin and casts and has a lower specific gravity than in the vascular type. There is often a marked anemia and severe headaches with a tendency to die, at an early age, of uremia. The application of the renal function tests shows a marked kidney insufficiency. On the other hand, in the vascular type, the patient is generally 45 years or over with no history pointing to previous nephritis, who has had very little trouble for years, though he knew high blood pressure existed. The renal function tests are usually good, and the patient seems strong and robust and has little or no complaint. This class of patients die eventually of cerebral hemorrhage or heart failure. There is another group of patients that seem to fit into the vascular class for some years and who later develop signs of nephritis and renal insufficiency and die in uremia; it is estimated that ten per cent of the vascular type end in this manner. These have been classed as mixed forms or combination forms or malignant hypertension. That chronic nephritis may be present for years and progress slowly with very little decrease in renal function, is well known, and at times the differentiation between nephritis and arteriosclerosis is almost impossible. Despite the fact that at times it is impossible to make a clear-cut diagnosis, the renal function tests are of considerable prognostic importance.
by the following determinations:

1. The urine examination with special consideration of the microscopic analysis.
2. The ophthalein test.
3. The urea concentration factor of McLean.
4. The determination of the blood urea nitrogen.
5. Water concentration tests.

These procedures are familiar to all, with the probable exception of the urea concentration test of McLean, a test that was found very valuable

in distinguishing the types of hypertension and in short is carried out as follows: Fifteen gms. of urea are given at 8:00 A. M. At 9:00 A. M. the first urine is collected and discarded; at 10:00 A. M. the second urine is collected and analyzed for urea. Less than 2 gms. of urea per 100 c.c. of urine means poor kidney function; normal kidneys are capable of concentrating urea 70 times, or more, its concentration in the blood. Thus if a sample of blood is found to contain 20 mgms. of urea per 100 c.c., and the urine at the same hour as the blood was drawn shows a concentration of 1,400 mgs. per 100 c.c. (114 per cent), it is obvious that blood urea as it appears in urine has been concentrated 70 times. This figure represented by

$$\frac{\text{milligrams urea per 100 c.c. urine}}{\text{milligrams urea per 100 c.c. blood}}$$

may be as low as 10 in nephritics. This quotient is referred to as the "urea concentration factor."

Taking for example a clear cut case of chronic nephritis with hypertension and one of the so-called diffuse hyperplastic arteriosclerosis the following table illustrates the usual findings:

When confronted with a case of chronic hypertension, with albuminuria and casts, the application of these measures is a fairly accurate guide in telling what the future holds for the patient. If one finds that there is no decrease in kidney function, and that the heart is greatly enlarged, and the other findings indicate that the patient belongs to the vascular class, he may offer a good prognosis with, of course, certain reservations. What will happen to this patient is hard to determine with any certainty because the potentiality of the heart muscle and the capability of the blood vessel walls to withstand strain are practically unknown quantities. However, if the kidney function is found greatly reduced as judged from all the tests, it is quite certain that the patient has not long to live.

ANALYSIS OF CASES

We have analyzed 299 cases 199 from the records of the M. C. H. from 1922 to Aug. 1926, and 100 cases from the private practice of one of us (L. M. W.), not selected, but picked out of the files at random from 1913 to 1920. The types of cases which enter a County Hospital are different from those which come to the office. The former are ill, confined to bed, in the terminal stages of disease as a rule. The latter are ambulatory, have few or no complaints and at times high blood pressure is found in routine examination. Necessarily then there will be a slightly different classification of the two groups. Frequently by the time the patient enters a hospital quite incapacitated, his blood pressure does not represent his actual circulatory status. Bearing this in mind we have divided the hospital group into two classes, the essential or vascular or arteriosclerotic hyperplastic (Evans) hypertension and the chronic glomerular nephritic hypertension. According to Hering,[9] Kylin[10] and others the former group represents more of a neurogenic or vegetative sys-

CHART I

Showing the Findings in a Few Illustrative Cases of Chronic Glomerular Nephritis

Name	Age	Date	B. P.	Blood Urea N.	U. C. F.	P. S. P.	Edema	Alb.	Casts	R. B. C.	Heart	Diag'sis	Eye-Gro'ds	Remarks
L.S.	38	7-19-24 7-27-24	250-160 220-105	37 48	— —	12 5	No No	III III	Hyal. Gran.	Many Many	III III	Chr. Glom. nephritis		Died 6-17-25 Uremia
J.K.	41	10-25-24 5-28-25 7-15-25 12- 1-25	220-120 220-118 190-120 220-118	25 35 65 45	— 45 — 14	40 40 33 15	 Yes Yes	III III IIII IIII	Gran. Gran. Hyal. Gran.	Many Few Few Few	enlarg	Chr. Glom. nephritis	Dissem choroiditis	Died 12-19-5 Uremia
S.C.	33	10-27-23 7-13-26	190-115 230-130	— 93	— —	— 3	III III	— IIII	— Gran.	— Many	III	Chr. Glom. nephritis	Papillary edema choroid retinitis	Died 8-10-26 Uremia
G.L.	37	2-24-25 2-29-25	185-110 165- 95	98	10	7 2	II III	IIII II	Gran.	Many	IIII	Chr. Glom. nephritis	Old and recent hemorrhage	Died 3-1-25 Uremia
F.D.	34	6-24-24 6-25-24 7-28-24	180-110 180-110 190-120	65 74 —	18 24 —	7 15	Ankle III	III	Gran.	some	No enlarg	Chr. Glom. nephritis	Alb. retinitis	Disch. Improved

tem disturbance without kidney inflammation, the latter is a general disease affecting the kidneys and finer blood vessels but still according to Hering having a neurogenic element.

Of the 199 cases of the County Hospital series, eighty-two, or forty per cent, were of chronic nephritis type; 104, or fifty-two per cent, were of the diffuse hyperplastic arteriosclerotic type; and sixteen, or eight per cent, were the combined type. But of the eighty-two nephritic patients, twelve developed uremia and died; of the arteriosclerotic group, thirty-one, or twenty-nine per cent, had a cerebral hemorrhage; nineteen, or eighteen per cent, died of heart failure. Of the cases classed as mixed or malignant hypertension five died in the hospital, two of uremia, three of heart failure. The accompanying charts give an idea of the progress of some of these cases; a few cases of each group on whom a postmortem examination was performed were selected for illustration.

Of the series of 100 cases there were 46 cases classed as essential hypertension, 18 cases classed as chronic glomerular nephritis, 36 cases classed as arteriosclerotic.

Sixty-two per cent (30) of the last group were between the ages of 50 and 70 with 14 males and 22 females. Seventy-two per cent (33) of cases of essential hypertension were between 40 and 60 years, while 62 per cent (28) of the arteriosclerotic group occurred between 50 and 70 years. The majority of the cases occur in the three groups in the period between 40 and 70 years with cases occurring below 40 in both the essential hypertension and chronic nephritic group. It would appear then that the arteriosclerotic hypertension comes on at a later age than the other two groups, and people who have this type are found frequently in the decade between 70 and 80 years. This is just what one would expect. The essential hypertension cases not infrequently are found in the early twenties. There is a strong hereditary element as Weitz[11] and O'Hare[12] have shown. Most authors regard this type as the result of spasm of the arterioles. After years there are changes in the arterioles not only in the kidneys but in the vessels elsewhere leading to the connective tissue and hyalinization of the media. This corresponds to Gull and Sutton's[1] arteriocapillary fibrosis, to Volhard's benign nephrosclerosis. The afferent arteries of the kidney glomeruli become narrowed and certain glomeruli become cut off from their blood supply. Fibrosis and hyalinization result so that certain areas of the kidneys resemble areas in a kidney the subject of chronic glomerular nephritis. There is no inflammation however in essential hypertension.

ILLUSTRATIVE CASES

The following is an illustrative case of chronic glomerular nephritis. (See chart I.)

The patient, a colored woman, aged 24, entered the Milwaukee County Hospital on July 14th, 1926, complaining of sore throat, violent headache, nausea, vomiting and dyspnoea. The past history revealed that she had a severe attack of tonsillitis in 1922, following which, edema, headache and bloody urine which kept her confined to bed for seven weeks. After this attack she recovered to the extent that she could go on with her housework, but felt poorly and was annoyed with headaches almost constantly. She had received very little medical attention and it could not be determined whether or not the blood pressure was elevated. About July 10th, 1926, she was taken with a severe sore throat, followed in a week by edema, violent headaches and vomiting and the other symptoms that brought her back to the hospital. The physical examination elicited a well developed negro woman, who was very stuporous and almost unable to answer questions. The tonsils were greatly enlarged, red and seemed severely diseased. There was a moderate degree of anasarca, the pulse full and bounding, and the radial arteries after the blood was squeezed out, were found not thickened. The heart, aside from slight enlargement, was found normal. There was some ascites. The blood pressure was 210/130. The urine contained albumin 3, many red and pus cells and many granular casts. The specific gravity was 1010. A complete blood count showed the following: W. B. C. 9,400, R. B. C. 2,600,000; Hb. 6.2 gm. per 100 c.c.; neutrophiles 78 per cent, lymphocytes 20 per cent, basophiles 2 per cent. The red blood cells were larger than normal and some deformity was present. Chemical examination of the blood gave the following results: Urea nitrogen 92 mg. per cent, creatinin 10 mg. per cent and calcium 8.1 mg. per cent. Renal function tests were done and the P. S. P. was found to be 3 per cent in two hours; the urea concentration factor was 10; hot packs and other measures for the

prevention of uremia were vigorously applied with fair results; the renal function tests did not, however, show improvement. After three weeks of treatment she developed uremia and died in coma. An autopsy was performed and in brief revealed a pair of white granular kidneys; the right one weighed 56 grams, the left weighed 75 grams. On microscopic examination, a typical glomerular nephritis was found. Diagnosis: Chronic glomerular nephritis.

SECOND CASE

The next case is an example of the vascular type of hypertension. (See chart II.) P. J., aged 44, was brought into the Milwaukee County Hospital on July 25, 1926; he was unconscious and had a complete right-sided hemiplegia of a day's duration. He was a large muscular florid looking man accustomed to hard work. A brother with whom he lived said that he had always been well, never missed work and had never been sick, but on questioning, a history of having been denied life insurance three years previous was obtained. The evening before entering the hospital, while dressing, he suddenly fell over, became unconscious and paralyzed on the right side of the body. The heart was seen to strike in the sixth I. C. S. outside the nipple line; a soft systolic murmur was heard at the apex. The blood pressure was 240/130. Urine analysis reveals albumin 2, few hyaline and granular casts, few pus cells and no R. B. C. The specific gravity was 1025. Blood analysis showed 21 mg. of urea nitrogen and 1.5 mg. creatinin. The other function tests could not be applied with accuracy because the patient sank rapidly into unconsciousness and died the day after entrance to the hospital. An autopsy showed an extensive hemorrhage into the brain substance on the left side. The heart weighed 750 grams, no valve defect seen. The kidneys were smooth and not contracted, the surface was normal. The cortex was narrow and there was an increase in the pelvic fat. The vessels stood out conspicuously. The microscopic examination of the kidneys showed the following:

The blood vessels, especially the smaller ones of the kidney, were thickened, and the lumen in places was practically obliterated. Many glomeruli were fibrosed, and some were shrunken while others appeared quite normal. The cells of the tubular epithelium were swollen and had undergone considerable degeneration. It was easy to see that the vascular system bore the brunt of the attack.

CHART II

Showing the Findings in Illustrative Cases of Diffuse Hyperplastic Arteriosclerosis

Name	Age	Date	B. P.	Blood Urea N.	U. C. F.	P. S. P.	Edema	Alb.	Casts	R. B. C.	Heart	Diag'sis	Eye-Gro'ds	Remarks
L.K.	52	5-28-24 6- 5-26	208-100 190- 95	33.5 28.6	40 50	55 60	0 0	0 0	0	0	IIII	Arterio-sclerosis diffusehy-perpl'tic		Disch.
E.S.	32	11-23-25 2- 1-26 4-12-26	180-110 200-110 185-100	15 20 33	56 45 39	50 30 —	0 0 0	III III III	Hyal. Hyal. Hyal.	II II II	IIII IIII IIII	Arterio-sclerosis diffusehy-perpl'tic		L.and W.
M.R.	52	1-28-24 2- 9-25 8- 5-25	230-130 220-115	14.1 26.5 18.9	41	47	0	IIII II II	0 0	Few Few	IIII IIII	Arterio-sclerosis diffuse hyper-plastic	Arteries thin and tortuous Arterioscle-rosis.	Died 9-23-25
N.W.	34	4-23-25 4-28-25 5-20-25	230-160 180-120 190-110	28 19 —	65 50	30 35 40	0 0 0	III 0 0	0 0	Few 0	III III	Arterio-sclerosis diffuse hyper-plastic		Disch. good con-dition.
P.J.	44	7-12-26	240-130	21.6	—	—	0	II	0	0	IIII	Arterio-sclerosis diffuse hyper-plastic	Increase of light reflex vessels thin and tort-uous no retinitis	Died Cerebral Hemor-rhage

THIRD CASE

Just why a few cases of diffuse hyperplastic arteriosclerosis may go along for some years and finally develop renal insufficiency with the symptoms of nephritis ending in uremia is not clear. An illustrative case is the following: A white man, aged 46, a carpenter, first entered the Milwaukee County Hospital November 7, 1923, complaining of shortness of breath and puffiness of the ankles. The heart was greatly enlarged but aside from a systolic mitral murmur no evidence of valvular defect was made out. The kidney function tests showed normal findings; there was, however, a trace of albumin with a few hyaline casts and pus cells in the urine. After two weeks he felt well, was free from symptoms and left the hospital. On September 27, 1925, he re-entered the hospital with the same complaints as on the first entrance but in addition suffered from severe headache, blurring of vision and precordial pain. The urine now contained considerable more albumin, had a specific gravity of 1015 and granular casts were numerous. The blood urea nitrogen had risen to 36 mg. per 100 c.c. and the P. S. P. tests showed 45 per cent in two hours. There was a urea concentration factor of 46. On December 14, 1925, the urea nitrogen was 57 mg. per 100 c.c. and the P. S. P. had fallen to 25 per cent. His kidney function failed rapidly from this date on and on February 19, 1926, he died of uremia. Autopsy findings: The heart weighed 728 grams. No valvular defect was made out. The kidneys were smaller than normal with capsules which stripped with ease leaving a finely granular surface. The right weighed 105 grams, the left 95 grams. Microscopically the blood vessels and especially the walls of the afferent vessels, had undergone hyalinization and sclerosis. The glomerular capsules were thickened and epithelial crescents were seen. Diagnosis: Malignant hypertension.

FOURTH CASE

As an example of the arteriosclerotic type of high tension the following may be cited.

Mrs. F., a widow, aged 59 years was first seen November 11th, 1913, complaining of being run down. There was no history of cardiac disease in the ancestry. She had always had good health. Twenty-five years ago she had an attack of catarrhal jaundice. For the past few years she has had some stomach trouble for which she has been treated by lavage. She has had several children. No miscarriages. She passed through a normal menopause at the age of 48 years. Recently she lost a little weight. She had no urinary symptoms, no cardio-respiratory symptoms. The bowels were regular.

Recently she was told that she needed an operation for catarrh of the bile ducts.

On examination, she was a large, well nourished woman. The skin had a slightly muddy color. The apex beat of the heart was in the fifth intercostal space, about 11.5 cm. from the midsternal line. Owing to abundant fat and large mammary glands it was difficult to locate it. The radial pulse was large in volume, regular, the artery thick and easily palpable, rate 82 to minute. The brachials were easily rolled under the finger. There were no murmurs over the heart. The aortic second sound was accented. The blood pressure in both arms was 170/100. There were no other abnormal findings. The urine showed only an occasional hyaline cast. There was no albumen, no sugar.

She is now (1926) 72 years old and in good health, Her son, himself a physician, reports that she has been able to do what she wished during the past 13 years. She has had no operations. At present her blood pressure is 190/110 and the urine is negative.

FURTHER CLASSIFICATION

For a number of years one of us has felt that there should be a further division in the essential hypertension group of cases which seem to be of a different nature. In the first place there is no history of cardio-vascular disease in the antecedents. In the second place the majority of the cases are found in people fifty years or over, whereas the majority of cases of essential hypertension are ten years younger and not infrequently cases are seen in people in the twenties. In the third place the blood pressure tends towards a definite type, a fairly high systolic pressure and a normal or only slightly elevated diastolic pressure. The diastolic pressure is around 100 m.m. of Hg., often never going higher than 90 m.m. This is different from the essential hypertension in which both systolic and diastolic are, as a rule, high. However, if we accept the theory of arterial spasm as the cause of the essential hypertension there are times when the spasm is not so great and the whole blood pressure picture is reduced, the diastolic falling to 100 m.m. or even below that

point. In the fourth place the superficial arteries of the arteriosclerotic hypertension case are quite different from those of the essential hypertension case. The former are large, very tortuous, thick-walled and not always uniform in thickness. The arteries of the latter are not tortuous, they are not large, they feel hard, the hardness of muscle in spasm. Neither type shows any pathological or functional kidney change, nor is the N. P. N. of the blood increased.

In men the condition seems to be associated with intense application to business combined with over-eating and lack of sufficient exercise. It has seemed that men accustomed to considerable exercise in their early manhood and who settle into office positions, gain weight and over-eat, are prone to acquire this type of hypertension. It is at present quite impossible to say what part the endocrine glands play in the development of this high pressure after 50 years. In women it is impossible at times to separate this group from that of the menopause. The endocrine gland changes in women at this age period, are more profound than in men and there can be no doubt that many cases of hypertension in women are the result of these changes. The prognosis in these cases is better than in the chronic glomerular nephritis group and about the same as in the essential hypertension group. The following is a tabular summary of the 100 cases.

ESSENTIAL HYPERTENSION

46 Cases

Ages 20 to 30— 2 cases
30 to 40— 8 cases
40 to 50—19 cases
50 to 60—14 cases
60 to 70— 2 cases
70 to 80— 1 case

33 or 72% between 40 and 60
23 male, 23 female

END RESULTS

23 cases unknown
23 cases known
1 case has diabetes now (since 1921)
9 cases are in good health (1913 to 1926)
1 case poor health (1915, age 63. Stroke in 1925)
8 died of heart failure
2 died of apoplexy
2 had apoplexy, recovered, later died of heart disease

ARTERIOSCLEROTIC HYPERTENSION

36 Cases

Ages 40 to 50— 1 case
50 to 60—19 cases
60 to 70—11 cases
70 to 80— 3 cases
80 — 2 cases

30 or 62% between 50 and 70
14 male, 22 female

END RESULTS

7 unknown
16 good health (5—10 years)
13 dead
8 heart failure
1 aneurism
1 coronary thrombosis
1 subacute bacterial endocarditis
1 following gall-stone operation
1 diabetic coma

CHRONIC GLOMERULAR NEPHRITIS

18 Cases

Ages 20 to 30— 1 case
30 to 40— 6 cases
40 to 50— 3 cases
50 to 60— 4 cases
60 to 70— 3 cases
70 to 80— 1 case

9 or 50% between 30 and 50
9 male, 9 female

END RESULTS

5 unknown
1 living
12 dead
7 uremia
1 apoplexy
1 carotid aneurism
2 heart failure (cardio-renal)
1 sudden

It is seen that practically all of the deaths in the arteriosclerotic group were the result of heart failure. In the essential hypertension group, as might be expected from the circulatory strain, the majority died eventually of heart failure but two had apoplexy alone as causes of death and two had apoplexy and later died of heart failure. None of these cases had uremia although many had a slight amount of albumin and a few hyaline and finely granular casts off and on during life. These two types, or if combined into one as most authors do, do not die of the consequences of kidney insufficiency. They are strictly cardio-vascular conditions. When we look at the causes of death in the chronic glomerular nephritic type we find the greatest number died of uremia although apoplexy and heart failure also were causes of death. The term cardio-renal disease should be confined to this type when heart failure sets in, as in the combination of cardiac breakdown and renal insufficiency.

High blood pressure may be carried by individuals for many years with no apparent detriment to their health or to their normal mental and physi-

cal activities. This is worth emphasizing. So much has been written about the dangers of high blood pressure that the average person is much concerned when he finds out that his pressure is high. It is not the high pressure alone which determines the prognosis. The family history has some bearing on the case. Weitz[11] showed that where there were deaths in both parents from cardio-vascular accidents, particularly apoplexy, the children had a shorter expectation of life than when one parent only died of such disease. The persistent high diastolic pressure over 130 m.m. Hg., has a bearing upon the prognosis. Yet individual cases live for years carrying such a load. Without any reliable tests to measure the efficiency of the heart muscle accurate prognosis must necessarily be difficult.

We can say that in the type called essential, death comes by apoplexy or heart failure. In the chronic nephritic type uremia is the commonest cause of death, with heart failure and apoplexy also as causes. In the arteriosclerotic type heart failure is by far the commonest cause of death.

Further, our analysis shows that when chronic glomerular nephritis occurs before the age of 40 it is malignant in type. Such cases are the result of acute glomerular nephritis which rapidly takes on chronicity with eye-ground changes and rather rapid renal insufficiency. These are quite different from the cases of edema with large amounts of albumin and casts but no blood cells which show high cholesterol in the blood, often milky blood serum, doubly refracting lipoid crystals in the urine but no eye-ground changes and no increase of blood pressure. These are cases of what are called lipoid or chronic nephrosis and have nothing in common with chronic glomerular nephritis. The only connection is that in the latter type of case, edema may set in, albumin be increased in the urine and the doubly refracting lipoids may be found. Then nephrosis has been added to nephritis.

The cases after 50 which are chronic nephritic in type run a milder and longer course. With attention to hygiene and diet such persons may live comfortably for years. The pathological changes in the kidneys are inflammatory with loss of glomeruli, but they proceed slowly barring accidental infections. Eye-ground changes occur in this type; narrow arteries and hemorrhages which in resolving leave flame-like scars.

Certain cases of essential hypertension of years' standing show pathological kidneys. The kidneys are contracted uniformly, are firm, the surface is coarsely granular, but the capsule strips readily and the cortex is thinned. The glomeruli are difficult to see. They seem reduced in number. Microscopically the kidneys show the most striking changes in the blood vessels. The arterioles are thick, their lumina are narrowed or even closed. Many glomeruli are fibrosed or hyalinized but others appear little or not at all changed. The process is evidently vascular with replacement fibrosis as the result of anemic necrosis. Enough normal kidney tissue is left to take care of the

CHART III

Showing the Findings in a Few Cases of Malignant Hypertension

Name	Age	Date	B. P.	Blood Urea N.	U. C. F.	P. S. P.	Edema	Alb.	Casts	R. B. C.	Heart	Diag'sis	Eye-Gro'ds	Remarks
G.H.	46 48 50	9-10-22 11-20-24 6- 1-26	200-115 190-100 230-110	— — 57	— — 10	— — 5	0 0 IIII	II II III	— Gran.	— III	— IIII	Combined form	Old and recent hemorrhage	Died Uremia
F.W.	45	9-27-25 12-14-25	195-115 215-130	35 57	46 —	45 30	III III	IIII IIII	Gran.	III	IIII	Combined form	Irregular white patches vessel tortuous	Died 2-19-26
E.H.		12-24-24 11- 5-25 2-27-25	280-100 235-140 230-125	21.5 36 23.7	 25 22	10 12 16	0 III 0	0 III III	0 Hyal. & Gran. Gran.	0 III III	IIII IIII IIII	Combined form		Died Cerebral hemorrhage
R.O.	49	9-21-23 8-15-25 8-20-26	200-110 255-140 215-135	22 28 57	— — —	40 30 15	0 0 IIII	II III III	Few	III	IIII	Combined form	Albuminuric retinitis vessels tortuous	Living

excretion from the body. No insufficiency is found during life.

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Liver Extract and Blood Pressure*

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I wish first to express my sincere appreciation for the honor conferred by an invitation to address you today, and second to say that I agree in toto with every word Dr. Miller has said. Like him, I too will take off my hat to any person who can cure arterial hypertension, because I cannot.

After making a few remarks on my conception of what hypertension really is, I am going to show a series of slides illustrating the results obtained in a series of thirty-four cases which have just been treated. I will say more about that when I come to the slides.

Arterial hypertension, i. e., blood pressure above the normal of a healthy person while at rest, is supposed to be due to an increase in peripheral resistance dependent on constriction of the arterioles. Sometimes this constriction can be shown to be the result of anatomical changes in the walls of the blood vessels, but usually no such changes can be detected, and it is supposed by many that the constriction arises from stimulation of the muscular coats of the arterioles by some abnormal substance arising through deranged metabolism. Certain pressor amines have been discovered which will cause this stimulation of the muscular coats of the arterioles and a rise in blood pressure, and the abnormal substances referred to are believed to be related to those amines. It is also believed that other substances related to other amines cause blood pressure to fall, not by acting on the arterioles, but because they cause the capillaries to become dilated, and it is possible that the degree of peripheral resistance and the dilating capacity of the capillaries are normally regulated by the presence in the blood of various depressor amines, or substances related to them, and that hypertension is due to a derangement of the blood metabolism by a preponderance of those causing increased tonic contractions of the arterioles over those causing dilations.

It has been known since 1891 that extracts of various animal tissues cause blood pressure to temporarily fall when injected into the veins of an animal, and it was thought that this depressor action was due to substances related to lower proteins. It was found, however, that cholin, a constituent of lecithin, has a similar action, and the most important work in this direction were the investigations of H. H. Dale and his collaborators Laidlaw, Richards, Barger and others. As an outcome of their discoveries it came to be realized that in most cases one of the amines, especially histamine, is usually the responsible agent. In investigating the action of histamine it was noted by Dale that the fall of blood pressure depends on dilation of the capillaries, and this far-reaching discovery overthrew the opinions of earlier investigators that the capillaries are incapable of dilating or contracting independently of changes in the amount of blood flowing into them through the arterioles. Dale's important discoveries were soon followed by those of Krogh, who microscopically examined the capillaries in the skin and in various membranes and muscles, and who succeeded in devising a number of experiments by which these vessels could be caused to constrict or dilate quite independently of changes in the arterioles. While these investigations by Dale and Krogh demonstrated that the capillaries, and other blood vessels of different parts of the body do not behave alike in their reactions to histamine

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and other amines, and have opened a way to an understanding of the causes of high blood pressure, little is as yet known as to the essential nature of the cause for this condition. Meanwhile, other workers, especially J. J. Abel in 1919, showed that the depressor action of most extracts of organs and tissues is due to the presence in them of histamine, and it is almost incredible how a small trace of this amine can temporarily lower the blood pressure. Choline, another depressor substance has also been found in most tissue extracts. Since it is now known from the work of these investigators that certain amines will temporarily lower blood pressure, it is possible that the whole problem of pressure balancing may be wrapped up in the amines, and that derangement of the amine equilibrium may be responsible not only for hypertension, but for hypotension as well.

LIVER EXTRACT

During the past thirty-five years there have appeared in the literature many articles dealing with the effect of *organ and tissue extracts* on blood pressure. Four of these deal specifically with the effect of *liver extract* on blood pressure. In 1891 Heidenhain[1] published for the first time a record of an experiment showing a temporary fall, following an intravenous injection of liver extract. Some eighteen years later, in 1909, Bingel and Strauss[2] made a series of similar observations. They found that extracts of the liver always gave a temporary fall in blood pressure when administered intravenously in laboratory animals. In 1911, and again in 1912, Miller and Miller[3] reported their findings that extracts of the liver invariably gave a temporary fall in blood pressure in experimental animals. In 1919, Abel and Kubota[4] described a marked temporary fall in blood pressure following the intravenous injection of an extract of the liver, and discussed the possibility of the histamine content being responsible for this action. They described in detail their phosphotungstic acid method of purification.

These early experiments were all carried out by intravenous injections in laboratory animals. There is no record of any observations having been made following either intramuscular or subcutaneous injection. There is no record of any injections having been made in the human being.

The effect of liver extract upon blood pressure I first observed clinically in December, 1924, in a study on another problem. Because of the striking phenomena observed, a series of thirty-three cases of clinical essential hypertension were studied with the extract and the results were so encouraging that it was decided to at once begin an intensive physiological and chemical study of liver and tissue extracts.

We have intensively studied the physiological effects of the extract on laboratory animals[6]. When injected intravenously, intramuscularly and subcutaneously, the effect is markedly similar to that produced by histamine, but much more prolonged. The effect on kidney volume, on the uterus horn of the virgin guinea pig, and on the heart are similar to histamine, though to produce the same results, requires many times the amount of histamine contained in the extract. The lethal effects, whether administered intravenously, intramuscularly or subcutaneously, are also similar to those produced by histamine, though once again, it requires of histamine many times the amount contained in the extract.

The blood pressure is however only temporarily lowered after an injection of histamine, whereas a characteristic feature of the extract is the prolonged effect in lowering blood pressure both in laboratory animals and clinical cases. Histamine in the cat, in doses up to 1 mg., will produce a maximum fall in about twenty minutes, the normal being regained well within an hour, whereas with doses of extract, which as far as can be judged from chemical analysis, could not contain anything like this amount of histamine, the blood pressure may remain depressed for several hours. This indicates that the extracts probably contain other depressor substances, or agents which supplement or activate histamine. It is recognized that the chemical methods for the detection and estimation of histamine in organ extracts are not entirely dependable, but in face of the numerous unsuccessful trials which have been made by various methods to identify its presence in the extracts, in any such quantities as would cause a prolonged lowering of blood pressure, such as is obtained by one or two cubic centimeters of extract, it seems safe to conclude that histamine is not mainly responsible for the effects.

Both the toxicity tests on laboratory animals, and the effects of the extract on the isolated heart, have not revealed any unfavorable action which would contraindicate their repeated injection into man. No anaphylactic reactions have been ob-

served. No definite conclusion can yet be drawn as to the clinical value of these investigations.

CLINICAL VALUE

I wish to say that we are not able to make any statement as to the clinical value of these extracts. It will be a long time before any conclusion can be arrived at.

Dr. Dale, of London, England, did a great deal of work with these extracts on laboratory animals, and, some six months ago, he wrote us to the effect that he felt reasonably sure the results being obtained were due to the effect of histamine in the extract. I accordingly carried out a series of experiments to demonstrate if this were correct. I took a series of six patients on whom extract had been used some months previously, and who did react well to the extract, whose pressures fell and remained at a lower level for several weeks, but who by this time had gone back to the point where they were before the extract was given, and on those patients I carried out a series of experiments, using histamine independently, choline independently, and histamine and choline combined.

We found that whereas we did get effects with the extract that contained histamine, according to our calculations, in doses of 1/100 of a milligram per cubic centimeter; where we used histamine in the pure form in doses as large as one milligram three times a day we got no results.

This was carried out on six patients. We need to do it on a great many more, but in the meantime it looks as though the histamine had no effect.

In the series of cases that I am going to show now, there are thirty-four all told. We divided those into three groups. In the first group we used the extract in a comparatively crude form, just sufficiently purified that it could be given subcutaneously or intramuscularly. I will show three charts of that, (1) the full number of cases, (2) where we got comparatively good results, and (3) no results at all.

The second series was the same extract purified to a very much greater degree, but still containing histamine in the quantity of 1/100 of a milligram per cubic centimeter. The third series of charts I will show was treated by the purified extract which, as far as we can tell, contains no histamine. I cannot say that it contains no histamine, but as far as we can tell it contains none. We know that histamine in doses smaller than .001 milligram in a cat will cause temporary but definite fall in blood pressure, which will regain its normal equilibrium in ten to thirty seconds, but in this extract in doses in the cat as high as two and three cubic centimeters no quiver in the pressure was produced, consequently we feel that it contains no histamine.

We have used a maximal normal systolic pressure of 140 and a maximal normal diastolic of 100. We used those lines in a purely arbitrary manner in order to have something definite on which to base our findings. In this first series there are fifteen cases, and this is a chart of the whole fifteen carried out over a period of fifteen days. The average of the fifteen cases on commencement was 194 systolic, 110 diastolic. After fifteen days' treatment, it was 142/86.

I might say that in these cases no patient was told what his blood pressure was. I have absolutely declined to give a pressure reading to any patient at any time because of the effect it may have.

In the first series we have the ten patients that we have classified as fairly good results, commencing with a pressure of 198/110, and coming down to 136/80.

In the third chart, we have classified those five patients where we feel we got practically no result. That was with the crude extract.

This second series was with the extract purified, except that histamine was not removed. We have a fall with the ten patients.

The second chart gives us the fall in the ones that are considered comparatively good, of six patients out of the ten, and the next shows the four cases out of the ten where no result whatever was obtained.

In this series we have nine patients treated by histamine free extract. This is a chart of the whole nine cases, with very little fall in diastolic, a more definite fall in systolic.

This is a list of seven cases out of the nine where the fall could be considered as comparatively fair, and the next chart shows the two cases where we got practically no result.

This is a chart of the twenty-three of the thirty-four that we have classified as comparatively good, and this chart gives us eleven cases where we feel we have no result whatever.

This is a composite chart of the three series. We found a greater effect from the histamine free extract in the diastolic than in the systolic. In the third series the diastolic commenced at 110

where we used the histamine free extract, and after fifteen days it was running along at 90.

SUMMARY

I do not wish any person to think for one moment that we even think we have found anything that will control blood pressure. We do not think so. We are simply showing these charts to indicate the possibility for study in this direction. My sincere hope is that some person may be able to isolate from this extract the active principle which does give us these results. I may say that in practically all these cases on cessation of treatment the pressure gradually goes back to the original level where it was before treatment was commenced, but on a second series when these patients are treated the second time, the pressure will fall more rapidly and will remain at a lower level for a longer period of time than on the first series of treatments.

If a third treatment is carried out somewhat later, after the pressure has returned to the original level, the same thing is true, but after the third series of treatments we sometimes find these pressures will remain at a low level for several months.

I can say that those cases where we obtained our best results were cases which we would classify as essential hypertension, cases that had not had a pressure very long, as far as we knew, cases where we had no demonstrable cardiac or renal involvement. The cases where we had our absolute failures were the cases of broken compensation, the cases where we had either a definite cardiac involvement or renal involvement, or both.

DISCUSSION

Dr. H. H. Milbee (Marshfield): The question of hypertension is one of the medical problems of the day. It concerns us all. We have listened to it from the clinical and the theoretical and the experimental sides. Dr. Murphy has already taken away my classification, although in a very small degree. I obtained this classification from Dr. Means of Boston. Since I studied it from that standpoint it has elucidated the question considerable for me. He places them in three groups. The first is the essential group, that is, the type without sclerosis and without nephritis; it is the vascular type. The second is the arteriosclerotic type with or without kidney, and is best called the hyperplastic sclerosis. The third type is the true chronic glomerular nephritis, which show secondary hypertension.

Group 2 may be a late stage of Group 1 and may be difficult to distinguish from it.

Group 3, that is the Bright's disease type, and glomerular nephritis, may resemble Group 2, but the patients of this group are in the fourth decade of life, the ages ranging from thirty to fifty, the average age being about thirty-five. We should learn the natural history of these types or groups. These patients complain of anorexia, nausea, vomiting, headache, physical disturbances, nocturia and polyuria. Forty-six per cent of them are anemic to some degree; nine per cent are obese. These patients are suffering from a toxemia.

The average age of Group 1, the essential type, is about forty-six. Their complaint is chiefly that of circulatory disturbances, palpitation, precordial distress or pain, chronic cough, dizziness, headache; they feel and look good; they act strong, but forty per cent of them are obese. It differs from Group 3 in the urinary findings and in renal function.

Group 2, the purely sclerotic, have an average age of fifty-seven. The symptoms here are hypertension with cardiac hypertrophy, and if they do not die of that cardiac failure they may develop a later nephritis.

Group 3 remain in a state of invalidism and at the best are doomed in a few years.

When we are confronted with a case of hypertension there are three questions we should ask ourselves. The first is, is there a nephritis; second, how much cardiac hypertrophy is there; third, how much diffuse arteriosclerosis is there?

The prognosis, therefore, depends upon these answers: The amount of nephritis and its stage, the cardiac hypertrophy and its extent, and the involvement of the circulatory system.

If these patients do not die of some inter-current disease, they usually die of one of three things: Cardiac failure, apoplexy, or uremia.

One of the best guides as to how they are getting along is a study of the pressure and the general well being of the patient. If we get a rise in diastolic pressure with a lowering of the pulse pressure, that is a sign of ill omen, and also a retinitis, from a study of the eyegrounds, in any of these groups is a sign of ill omen. A retinitis is present in the essential group only in a small number of cases, while in the second group it is somewhat greater, but quite common in the third group.

In these groupings we find in the essential type forty per cent of them are obese; probably some form of prophylaxis could be established by preventing obesity. Very few of us practice prophylaxis. The relationship of obesity to hypertension is not clear.

I agree with Dr. Miller about the alcohol, the tobacco, meat eating, infected tonsils and teeth, that they have a very small amount to play or form a very inactive causative agent in hypertension.

Dr. L. M. Warfield (Milwaukee): I think this symposium will have failed of its object if we do not carry from it one or two positive points. I confess that I agree with Dr. Miller in his pessimism. I do not feel, however, that it is altogether a truly pessimistic attitude, but rather an attitude of "we do not know." There is certainly one thing which we can gather from this symposium and that is the comparatively good prognosis of very many cases of high blood pressure. Years ago, as you will recall, when a patient came to us with

high blood pressure we drew a long face and we practically told him, if not in so many words, at least in our attitude, that the undertaker would get him before very long. We have learned a great deal since that time, and now we recognize the fact that there are people with very high blood pressure who have not only lived comfortably for many years but have carried on an enormous amount of work. I sometimes wonder whether it is not an advantage to a man to have high blood pressure. He learns his limitations and, barring unforeseen accidents, he will probably live as long as the so-called normal individual.

All cases of hypertension certainly do not have a bad prognosis. Some cases of hypertension do have a bad prognosis, and that is the crux of the situation.

Dr. Murphy has called our attention to the fact that the cases of chronic glomerular nephritis which always have hypertension are the cases which really are the serious ones. The cases of so-called essential hypertension, primary hypertension, vascular hypertension, hereditary hypertension, whatever one chooses to call it, are not the serious conditions which we formerly thought. Those cases which begin early in life, that is to say, between twenty and thirty years of age, are the more serious because of the fact that they seem prone to develop kidney lesions and are apt to die before forty years of age. The cases, however, which come on after forty years of age in which there are no evidences of kidney disturbances and in which the heart hypertrophies only after several years, may live a long time and lead a very active life.

In 1914 I called attention to a grouping of the cases of hypertension which I have used since that time and which seems to me to be helpful. If I heard Dr. Milbee correctly he apparently uses the same group. The first group was the essential hypertension, or as I then called it, the hereditary type. At that time there were no statistics, so far as I knew, which proved that this type really was hereditary. I noted only that in my cases there was almost invariably some cardiac lesion or apoplexy in the family record. Since that time Weitz in Germany and O'Hare and his co-workers in this country have analyzed groups of cases and have found that there seems to be a definite inherited tendency for the development of hypertensions. Weitz claims that if both parents show hypertension, the hypertension in the child develops at a younger age than in the parents, and it develops earlier if both parents showed hypertension than if one parent only showed hypertension.

These cases do not show any kidney insufficiency for years and may never show any kidney disturbances. However, many believe that hypertension causes vascular changes in the kidney which eventually lead to functional insufficiency.

Another group I called arterioselerotic hypertension. These individuals do not have any kidney insufficiency and they live for a long time. That group usually develops after fifty years of age. They have rather tortuous and large arteries. As time has gone on I have not been at all sure that in the women I could separate this group from the group that comes on during or after the menopause. It seems to me that we do see cases of hypertension in women during the menopause in which there is simply hypertension without any tortuosity or thickening of the vessels or without any marked enlargement of the heart. Such cases at times seem to be benefited by treatment with ovarian extract. These cases are subject to great fluctuations in pressure so that one has a distinct feeling that there is a large psychic element in them. Treatment of these people by any means whatsoever very often seems to reduce the pressure, but one should not be misled into believing that the treatment caused the reduction. I have patients at the present time whom I have followed for ten and fifteen years and the pressure is just the same to-day as it was when I first saw them. They are active and in good health.

The other group is the chronic glomerular nephritic group which Dr. Murphy has emphasized this afternoon. It is to this group which I have felt that the term cardio-renal disease should be restricted.

The prognosis of the cases seems to vary somewhat in that the cases of essential hypertension more often die of apoplexy or heart failure. They may have apoplexy, recovering with some residual paralysis, and then die of heart failure. The arterioselerotic type almost invariably die of cardiac failure. Occasionally they may have apoplexy. The chronic nephritic type have uremia or cardiac failure. Occasionally these cases have apoplexy but they are in my experience much less common than in the other two types.

We see then that when a patient comes to us with hypertension the important point is to determine whether we are dealing with a simple uncomplicated hypertension or whether the hypertension is associated with definite kidney disease. Although we may not be able to reduce the pressure, by regulating the lives of the people who have hypertension and allaying their fears, we can prolong their lives and help them to live happily.

Dr. P. F. Rogers (Milwaukee): Being a victim of hypertension myself and expecting at any moment to have to consult my undertaker, I am naturally interested in this symposium, and I came here largely for the purpose of hearing it. I was tremendously interested in what Dr. Miller had to say, which confirmed all of my own impressions in the study of my own and other cases. I might say that I am a member of a high pressure family, there having been four members, including my father, who were high tension victims.

Dr. Miller's remarks were very cheering to me. I have found that while I have experimented upon myself, as I have with my patients, in the various prohibitions and restrictions as to this, that and the other article of food, and so on, it seemed to produce no results whatever, and I have reached the conclusion which Dr. Miller apparently has, that it does not make much if any difference *what* a person eats, providing he eats *moderately*, and that restriction of the various physical activities within *reasonable* limits is all that is necessary. The reasonable limitations in any given case must, of course,

be regardful of possible existing arterial, cardiac or renal pathology.

Also I was naturally very much cheered to hear what Dr. Warfield had to say about my life expectancy, because most of my friends have encouraged me to believe that the undertaker already had my address and was waiting for me around the corner.

I rise, however, to ask one question of Dr. Macdonald. I gather from all the remarks made here today—and it has always been *my* assumption—that hypertension is merely a symptom. A symptom of what, everyone here seems to agree we do not know. If it is only a symptom, is *any* form of treatment aimed simply at that symptom going to produce any permanent result? Can any real benefit be obtained until we know and treat the cause?

The question I want to ask Dr. Macdonald is whether or not, in the series of cases which he has cited here, the patients, while taking the liver extract injections, were kept under continuous observation; whether they were hospitalized and kept at rest, or were going about their daily duties as usual. There is no question about the influence of quiet and rest in lowering hypertension, and if, as Dr. Miller pointed out, they were confined to bed and kept at rest during that period, it does not seem to me that the experiments would have very much significance. I should like to ask Dr. Macdonald to specify whether or not those patients were hospitalized and kept quiet.

Dr. R. S. Plumlee (Brooklyn): The question really is, what are you going to do about it? I have been experimenting with myself. I have consulted all the authorities that I know of that have ever written anything on this, and I can change my blood pressure in three or four days. At any rate, I can attend a few six-thirty dinners and run it up to 180 and 190. It was about 200 when I had apoplexy. I had paralysis of the muscles in the right side of the throat and symptoms all over the right side, but I went on working and keeping office hours. Now I live on vegetables mostly. I raise a garden. Exercise is one of the most important treatments with me. You can play golf, you can walk, you can do anything, but get exercise. When I am confined to the office in the winter, the blood pressure goes up. Then I starve a while. I am thinner now than I have been for thirty years, but I feel better than for four years.

Gardening is the very best exercise. Saw up your neighbors' shade trees for wood; cultivate a popcorn patch with one of those old sprouting hoes like they used when I was a boy, and you'll get plenty of exercise. However you can't take so much exercise if the heart or kidneys or both are involved.

Dr. N. P. Anderson (La Crosse): I want to know if giving these patients liver extract produced headaches afterwards.

Dr. Hugh P. Greeley (Madison): I want to emphasize the point brought out by Dr. Rogers, that we really should not come together and talk about the treatment or the prognosis of hypertension, because hypertension is a symptom. If we want the tail to wag the dog we want to go at it that way, but if we really want to get down to brass tacks and talk about arteriosclerosis or nephritis or any of the other causes that do produce high blood pressure, we will be attacking it properly.

Dr. Janeway, who introduced into this country and popularized the blood pressure apparatus, came to believe before he died that it had done more harm than good. There are a good many people now who agree with him on that, because we use the blood pressure machine to the exclusion of a good history and good physical examination and a thorough diagnosis.

High blood pressure and the treatment of high blood pressure as a disease have no place in a medical meeting any more than the treatment of rapid pulse. No one would get up and talk about the treatment of rapid pulse, because everybody knows that rapid pulse is a symptom of ten to twenty or a hundred different conditions. Blood pressure belongs in the same class. It is up to us to make careful histories and diagnoses and find out by that method and by clinical observation what essential hypertension is. Until we do that we do not know very much about what we are talking.

We know that in the majority of cases in which hypertension is a symptom there may be a profound metabolic disturbance, and in any metabolic disturbance of this nature we are justified in being careful about certain hygienic measures; and when we say that a case with hypertension cannot drink too much water, we are again having the tail wag the dog because there is no such thing as hypertension without something else. In one case it may be nephritis, in another case it may be arteriosclerosis or cardiosclerosis, but a patient can drink too much water from the point of view of his heart, although he may not be able to drink too much water from the point of view of his blood pressure.

When we say that high protein diet has no influence upon high blood pressure, we are again making a mistake in treating high blood pressure as a disease.

I don't know whether or not Newburg's work ever will be confirmed by other observers, but he produces arteriosclerosis and nephritis by high protein diet in animals. When we say that a patient should be allowed meat and eggs, it recalls to my mind the treatment of diabetes twenty years ago when we gave a person a list of forbidden articles on one side of a sheet of paper and permitted articles on the other. That is medieval stuff in diabetes now. We have to prescribe in some accurate way how much protein, how much carbohydrate and how much fat will be allowed.

In a metabolic disturabnce of this kind it is exactly the same question. We can allow them meat, to be sure, but we cannot allow them as much as they have been accustomed to in many cases. We should make a prescription of their diet and educate them to know how much they should eat as well as what kind of food.

I was glad to have Dr. Warfield say something about heredity in this condition, because that is an increasingly important factor in these cases, if you make a careful study of it.

Dr. F. D. Murphy (Milwaukee): Of course the prognosis does not depend entirely upon renal function tests,

but since it is very difficult to determine the potentiality of the heart muscle, it is hard to render a prognosis from the study of the heart especially in earlier cases. We do not know how long the heart will stand up under the strain. It is the same with the cerebral vessels; one cannot tell when the cerebral vessels have lost their elasticity and when they will rupture and will bring about a cerebral hemorrhage.

We believe entirely with Dr. Miller that it is not the quality of the food that one eats, but the quantity. That is, we believe that decreasing the total intake of food brings about better results in hypertension rather than curtailing some part of the diet, like meat, or some other type of food.

Dr. W. J. Macdonald (St. Catherines, Ontario, Canada): Replying to Dr. Rogers, I would say that I believe it is a generally accepted opinion that rest in bed or hospitalizing a patient will have a marked degree of effect on the pressure. If you put a patient to bed for one or two weeks, the pressure certainly will come down. For that reason, this series of cases that I showed today was not hospitalized. The patients went about their work as usual and ate any food they wanted. We did carry out a series of experiments last winter in which we put six patients in the hospital, kept them in bed constantly for two weeks, controlled their diet and gave them this extract, one cubic centimeter a day. We got a certain result. After that experiment was over we took the same number of patients from outside, had them go about their work as usual, eat any food they wanted to eat, and gave them the same treatment, one cubic centimeter of liver extract a day subcutaneously, and we had almost the identical result that we had with the six bed patients. Of the six bed patients we had four where we got definite results, we had two where we got no results at all. The six ambulatory cases gave us approximately the same results.

In this series of thirty-four we had no bed patients, none hospitalized, and they all ate what they wanted to eat.

In reply to Dr. Anderson as to whether liver extract produces any headaches immediately after injection, I would say that depends entirely upon whether there is any histamine in the extract. If there is no histamine, there will be no flushing, there will be no headache; if there is histamine there will be a definite flushing and a definite headache. The degree of the headache will depend upon the amount of histamine in the extract.

We know that histamine given intravenously in the laboratory animal will cause an immediate fall, but when that pressure goes back to the point where it was when the histamine was given, it does not stop there; as a rule it goes twenty or thirty millimeters higher and will run along at this higher level for some considerable time after the injection is given. That is what produces the headache in the clinical case that has been given liver extract with histamine.

Physiotherapy, Its Use and Abuse*

BY CURRAN POPE, M.D.,
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I wish to express to you first my very great appreciation of your calling me from my southern home in old Kentucky to come here and address you this afternoon upon a subject that in its interest and in its use in the medical profession is growing literally by leaps and bounds. It is a subject in which some of you are newly and vitally interested: it is a subject in which some of us have grown gray in the service; it is a subject that it behooves us at times to take stock of, as it were, to balance our accounts and to see if we are not missing some things, overlooking others, and in another way overestimating some.

A conscientious reviewer of the history of medicine probably would admit that within the last century, and largely within a half of that period, medicine, art and science have advanced with a speed incomparably greater than at any previous time. Philosophical speculation has given way to experimentation, as medicine has kept pace with the advancement of science in general. It would be as ungracious as it would be unjust to deny the great advance of medical knowledge along with the evolution of culture, and medicine probably can boast of many conquests that deserve to be called marvelous.

It sounds like a platitude, yet one welcomed by the practical doctor, to hear that observation, experience and sound judgment are oftentimes more important in clinical medicine than are measurements with delicate instruments. We have often maintained that the use of helpful material devices is not incompatible with the exercise of sane judgment; even the most hard-hearted physician usually finds a watch helpful in understanding the behavior of a heart.

There is much to justify one in the belief that the magical and irrational has increased because the critical faculty has been dulled by so many new wonders. Zinn gives us this statement: "Hard and conscientious work, accurate observation, sound reasoning, a mind free from obsessions and superstitions, a firm belief in the possibilities of medi-

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cine as an art and as a science—these are the things which have raised medicine to its present greatness, these are the things which will carry it onward always."

Every endeavor in legitimate medicine has its uses and, alas, its abuses. In physical therapy there have been many. Fundamentally we are therapeuticians of many kinds, neither medicinalists, nor physical therapists, nor yet mechanicians, as are the surgeons, but we are primarily physicians practicing medicine or surgery as a whole or in some subdivision or specific specialty. There has grown up the idea that specialties not in the domain of medicine but in a certain therapy constitute a definite specialism. Nothing could be further from the truth.

The primary and basic knowledge essential to the use of any therapeutic measure can be clearly outlined. Close acquaintanceship with disease and its symptoms, a knowledge of causative factors, the pathology and pathological anatomy of the diseased or disordered function, prognostic ability and general therapeutic knowledge. When we have mastered this information we are in a position to decide as to whether we shall employ any or all measures of relief.

Nor does this more or less complete knowledge of our disorder or disease place us in a position to apply physical therapy to the diseased process.

Every form of physical therapy has its peculiar and well recognized method of organization. We must know and understand how that particular energy is developed, how it is obtained. We must know from what source that energy is derived and how it is changed. We must know the action of each and every physical remedy in the domain of physics and chemistry. Here we do not even stop, but we must study its physiological action upon the normal individual and upon the pathological subject with all the variations of diseased states. Then and then only can we truly prescribe these measures, even as we would those chemicals or what we call medicinal substances or drugs that are subject to the accurate measurement of the chemist or the pharmacist.

If I may be permitted to speak to you a moment in reminiscent mood, I would let my mind's eye travel back over the vista of the years and bring again to memory's screen the early struggles of those who truly and justly bore and have earned the title of pioneer. I have seen the rise and fall, the battle and the struggle, the slow, painfully slow, but nevertheless steady growth of knowledge and enlightenment, until today, I stand with other defenders of the faith, reviewing in my mind the victorious passage of the now triumphal modalities. The agonies of body, the tortures of mind, the abysmal melancholy of rejection, are all forgotten in the healed wounds, the softened scars, in the joyousness of the success of a well merited victory. We can now, with a feeling of safety and certainty, "hang our banners on the outermost wall" and expect to hold our own "till Birnum wood do come to Dunsinane." "Now is the winter of our discontent made glorious summer, by this sun of York."

I have been a pioneer in the field of physical therapy. I have seen its agonies, I have seen its struggles, I have seen its rise, and God forfend I shall not see its fall.

From Kansas City in the good old days there started winding across the plains a wagon trail; it wound north and west in serpentine course, over hill and mesa, into the Rocky Mountains, and led eventually to the land of romance, to the land of promise, to the land of gold, to the land of hopes, and all along that trail were to be found mementoes of lost hopes, here the blanched and picked bones of horses and cattle, there popping up from the sandy soil of the plain that was later to blossom with flowers and ripen with grain, stuck the grim and grinning skull of some poor unfortunate man or woman who had been a sacrifice to the pioneer who possessed the land. Looking further we see the rims and the hubs of a wagon that once contained a happy, singing, hopeful people, and here a skeleton between whose ribs an arrow told the fateful tale of Indian massacre.

But the Anglo-Saxon is a hard person to stop. The pioneer continued to follow the trail over the mountains, until today the great west is peopled with a population of which America is proud, and were we to start a sinuous trail from doctor's office to doctor's office we would find also the skeletons of lost hopes, of disappointments, of failures, of misunderstandings, of dust-covered apparatus, slowly rotting and occupying valuable floor space.

Those were the days when a fellow rolled up his sleeves and if he was not able to carve out his destiny with his good right arm, figuratively speaking, he went down to defeat, and where one triumphed there were nine hundred and ninety-

nine of the skeletons and broken hopes that equaled the tragedies of the great trail from Kansas City to the West.

But time moves on, and physical therapy shifts into a stage with everything as the result of psychic influences. A great many of you do not recall the days when everything that was done by one using physical therapy was said to be the result of "*psychic influences* (?)," only to have the profession change this charming proposition later into the statement that it was due to "*suggestion.*" Suggestion did the work and not the current; results were due to suggestion, even though chemical, thermic and mechanical effects were plainly visible and easily demonstrable. It looked as though medicine and surgery were never to awaken from a Rip Van Winkle sleep to a realization of the value of physical measures in the domain of therapy. It really seems as though it takes some catastrophe to shake up the medical profession to a realization of things real.

Physical measures needed just such a catastrophic shock to put them on a firm foundation. It was a great war. Do you realize that it took the lives and blood of 20,000,000 people to make the medical profession of America realize that these treatments are real, actual, living modalities? It took a great war to make the medical profession recognize physical therapy.

PRACTICE VS USE

No man should *practice* physical therapy; he should *use* it in his work just as he uses any other therapy. It is not a thing to be trusted in unskilled hands. It possesses potent power for good, and like everything that possesses this power it has equally potent power for evil.

A great many men think they are using physical therapy. The putting of a pair of electrodes on an individual without all of the knowledge both physiological and pathological of which I have spoken is a good deal like the laying on of hands, neither of which amounts to very much in the long run.

The ancient Greeks in their wonderful mythology spoke of the innkeeper Procrustes. If an individual from among the gods came to the inn of Procrustes and he was too long for Procrustes' bed, he cut off his feet; if he was too short, he stretched him until he fit the bed. There are a number of Procrustes in physical therapy. There are a great many patients who go to a physician who has only a very limited outfit, who has but little knowledge himself, who is not practicing physical therapy but giving treatments—two very different propositions, but alas! what is a novitiate patient but a visitor to a modern Procrustes.

It is a very interesting fact that I think is capable of verification by those who know, that in this broad land of America there are today comparatively few men who are really qualified to teach the domain of physical therapy. I do not believe that anyone would be able to disprove such a statement.

This alarming lack of real teachers results in a good many colleges regarding physical therapy as the tip of the tail, believing that any old thing will do, that any "*old body*" can teach it, and that any old result will be satisfactory.

The deification of diathermy. Today the commercial man has erected a system of medicine about diathermy, a great deal of which has no real basis at all. Diathermy has been elevated to a pedestal, and from that godlike position it looks out upon the profession as a promised cure-all. This is one of the results of the commercialization in medicine of the high frequency current. A great many of the physical therapy men are a good deal like the detail man in the good old days before we had much of that foolishness stopped. Some of you will remember his pleasant and smiling countenance and plausible yarns concerning the remedy or the firm for which he worked, and he worked on a very excellent basis, just as others are working now, not only that a sucker is born every minute, but that Phineas T. Barnum was one of the wisest philosophers when he spoke about how people could be fooled.

STANDARDS FOR FUTURE

The time must come when a manufacturer and his representatives shall conform to the standards that will be laid down by the American Medical Association and when his agents must not only conform to that, but must conform to a moral status in their statements that is justified by what the current can or cannot do.

I will tell you a story. Down in my state, among the mountains, a very prosperous doctor lives who is a very great friend of mine. A detail man from a physical therapy house went into his office and said, "You ought to have a machine, a sort of pan-electric machine on which you can press a button and let it do all the rest." After a

very persuasive day or two days, he sold this doctor a machine on the basis, as the doctor afterwards told me, that I had made some success in my work in neurology and internal medicine by the use of this kind of machine. I regretted very much to be placed on such a low level, but it could not be helped. About two weeks afterward the doctor wrote to me and asked if I could tell him how and where he could get the galvanic current from that machine, also the faradic current and the sinusoidal current. I wrote and told him he couldn't get anything but an alternating current called the high frequency in its different forms and phases.

The same is true of actinic light, commonly called quartz light. I prefer to call it actinic light because it is a chemical light. It is being used now indiscriminately. What I have said of diathermy is equally true of this light. I warn all of you, at least in my opinion, that it will not be long before a great many of you will have a large number of these lamps that you would like to get rid of. The lamp has a very limited field, it is useful in a few and certain directions, but it is not the cure-all that it is represented to be by the different agencies.

How many of you know anything about galvanism, one of the oldest and most valuable currents in medicine? It is the great commercial current; it does your electroplating; it does a hundred things for the commercial people; it produces well-known and certain conditions of ionism and metallo-chemical action in the human body that it behooves every one who is a progressive doctor to know about. Today we see in the journals and hear of using the high frequency spark in electrocoagulation from the deified diathermy to overcome as simple a thing as a cervical erosion. There is a painful slough and an ulcer to heal when with the simple application of a painless galvanic current you can bring about complete healing without any discomfort to the woman. Procrustes to the front.

How many of you are interested in hydrology or hydrotherapy? When it comes to hydrotherapy, all other forms of physical therapy must bend the knee and bow the head in obeisance. This therapy is not new; it is old; it comes from the mists of antiquity and is hoary with tradition. It is good in nearly every phase of medicine. In fevers, in weakness and in strength, from birth to death we cannot avoid the use of water. In acute diseases we have sponging and bathing; we have lavage in its many forms. In chronic diseases we have a wide field in the various forms of baths to select from. This form of treatment has a wide effect upon the human body; it is without doubt above all others the greatest measure in this wide universe for the maintenance of good health for the physician himself. The man practicing medicine who has the will power and the strength of character to be able to take a warm shower and follow it with cold water winter or summer, out of the river or lake, will find that his health is benefited many, many times. I do not know what I would have done in my life without it. In my private hospital I am closely confined, I do not get enough of nature's sunshine and fresh air, but I have recourse to this greatest, this most valuable of all measures of therapy to maintain health, strength, mental and physical activity.

Do you know that in troubles of the extremities there is nothing to equal the whirlpool bath; that the whirlpool bath makes possible other treatments? Once again your diathermy can be given with much better effect following a whirlpool bath. A limb so tender that it cannot be touched will, after a whirlpool bath, be capable of manual massage.

You say this requires an institution, this requires expensive paraphernalia. That is true in many instances, but as I have repeatedly demonstrated before medical bodies, you can with a basin and a rough rag, a few towels rough and smooth, get some of the most marvelous effects from hydrotherapy that when once they are obtained and the doctor is not too inert to use his knowledge and teach the people how to use them, will prove of value in nearly every form of febrile disturbance.

The next time you have a cold or a sore throat, try the wet compress or pack around your throat and you will find what great comfort it will give you and how quickly it will help to heal the condition.

Do not forget that we should drink plenty of water. The modern human's tissues are usually dehydrated, and the drinking of plenty of water is a very valuable therapy. As was said today, it can be drunk in hypertension cases provided you have proven by a simple water test that your kidney can both dilute and concentrate the urine, and that is the crucial test of whether you should give or restrict water in hypertension; it is a ques-

tion of the ability of the kidney to do the work with the water in the blood. If the kidney is blocked you cannot give water. If the kidney is open you can drink freely.

Shall we drink cold water before, during or after meals? That wonderful myth that has lasted so long was experimentally broken to pieces by Dr. Hawk at the University of Pennsylvania some years ago. If you think it is going to chill your stomach, start out by remembering that the stomach is a great deal warmer than your mouth. Take a mouthful of ice water, hold your watch in your hand, and see how many seconds it takes to make the water brackish and disagreeable. Cold water upon the stomach, especially the empty stomach, is like cold water on the external surface of the body; it is one of the best, if not the best, tonics that we have, whether we use it internally in the stomach, internally as an enema, or externally upon the surface of the body.

What is a rational attitude, then? A rational attitude of the man who is to use physical measures is to use all measures. He should be so well fitted that he can pick here and there, with his knowledge of the needs and the necessities of his case, from his armamentarium those particular treatments, those particular measures and methods that will be of value to the patient, whether that patient be short or long or whether he is awake or goes to sleep.

Remember that diathermy is not a cure-all. Very careful claims should be made, and only those who have experience know how cautious one should be in promising too much.

Today we are in the throes of a new era. It is a dangerous one. It is an era when men are apt to misjudge and not to weigh, when they are apt to make of these remedies a panacea for the evils of flesh as well as of mind. *These methods have in themselves certain powers and capacities only as the intelligence of the physician may understandingly apply them.* Do carefully what you do, and do not overdo.

I do not want you to forget the men who worked so hard and bore so patiently the slings and arrows of outrageous fortune, who took up arms against a sea of trouble and fought on and on because of a faith not unlike that of the martyrs of old.

If I were to express a hope, it would be that I might see the final triumph of these things for which I have worked unceasingly. My hope and prayer is that I may yet be given, through the grace of God, time to see the full fruition, the complete recognition, the full evaluation of that which I have longed for, dreamed of, for which I have hoped and struggled. (Applause.)

DISCUSSION

Dr. J. C. Elsom (Madison): I have been intensely interested in Dr. Pope's very able presentation of the uses and abuses of physiotherapy, and yet I must confess that I have been somewhat amazed that a gentleman who comes from Kentucky so thoroughly and so vehemently advocates the use of water and hydrotherapy. (Laughter.)

I have known Dr. Pope for many years. I know of his intense interest in physiotherapy and physiotherapeutic measures. I know of the splendid work that he has done. I know also of how he employs all of these methods which go to make up that sometimes abused agency which we call physical therapy.

I want to say that my conception of physiotherapy is that it consists of those simple measures and natural means, if you please, which are oftentimes apt to be neglected by the medical profession. I think perhaps sometimes we depend too much upon our drugs, too much on the more artificial methods of therapy, and fail to realize that in the sunshine, in the light, and in these other simple things of nature, heat, exercise, massage, hydrotherapy, we have valuable agents, and when we neglect those things we are certainly leaving out of our therapeutic measures some of the most important methods of treatment.

I believe that physiotherapy in its last analysis is simply an adjuvant of medicine and surgery, that and nothing more.

Dr. Pope has very well said that it is not a cure-all; we certainly know that is true. But we do know that these physical measures often are clearly indicated; if heat is indicated, we can certainly administer it by the many methods which are at our disposal. So let me say that the value of physiotherapy consists of three things: In the first place, its thermal effect, by which, of course, we mean the application of heat by means of baking machines, so-called deep therapy lamps, and the infra-red and machines of that sort, diathermy, etc., which certainly will convey to the tissues a very beneficent and helpful form of heat.

Again, the effects of physiotherapy are due to their chemical action. We know this is true, for in the administration of galvanism, depending entirely upon which of the poles of the galvanic current we use, whether the positive or the negative, we obtain chemical results. It has a very decided and very important place in physiotherapy.

The third point that I want to bring out is that physiotherapy is due to its mechanical effects; by mechanical I mean massage, which, after all, is only a species of passive exercise. Not only in health, but sometimes in atrophied and ankylosed tissues we find that the mechanical effect of exercise is of extreme value.

I have been interested in physiotherapy for a number

of years, actively perhaps for the last eight or nine years. I think that we may compare physiotherapy, possibly, to a three-legged stool, that is to say that this third leg of the stool is a very necessary part of it; the other two legs we may say are medicine and surgery. So physiotherapy helps to bolster up the other two legs. I am not saying which is the most important leg of the three-legged stool; you can judge that for yourselves.

Sometimes I like to compare physiotherapy to the family, of which surgery is the man—bold, radical, necessary; medicine is the woman, comforting, healing, splendid; and physiotherapy is the child, although perhaps in this instance physiotherapy is the oldest of the three, because physiotherapy or physiotherapeutic methods have been practiced since the beginning of time. It is only in recent years when we have come to a scientific study of these methods that we have been enabled, I think, to place physiotherapy upon a very firm foundation and to use it as I have suggested, only as an adjuvant to medicine and surgery, and to use it only in those cases in which the effects are clearly indicated.

The advance in physiotherapy has been very interesting. The medical profession, of course, is conservative, as it should be, but this conservatism, this ultra-conservatism, has been in the last years broken down to a very great extent, and now we are coming to see the very great value of physiotherapy and to sift the wheat from the chaff, because we all know that in physiotherapy there is a great deal of chaff. I am also persuaded that in physiotherapy there is a very great deal of wheat.

I agree thoroughly with Dr. Pope when he says that physiotherapy should be taught not by the agents of electric apparatus who swarm into our offices and who tell us that by turning a certain button or switch we may cure all ailments; physiotherapy should not be taught in that way, but it should be taught intelligently and it should be taught by the medical colleges.

This is coming about. It has been remarkably true that within the last five years many medical colleges have taken serious consideration of the teaching of physiotherapy, so I hope the day will soon come when we may get our physiotherapy knowledge in the most scientific and the most wholesome manner.

Let me urge those of you who use physiotherapy in any of its methods to use it intelligently, to study the physiological effects, to know the physical effects of the machine and to know what you are trying to do. Only when this is done can we intelligently apply these methods of physical therapy.

In conclusion, let me say that in the Department of Physiotherapy in the Wisconsin State Hospital I think we have a very complete equipment, and I want to extend to you all while you are in Madison an invitation to visit that department and to see for yourselves, if you please, just what we are trying to do along that line in the State Hospital.

Dr. Joseph F. Smith (Wausau): I think it might be well to call your attention to the fact that pursuant to a resolution in the House of Delegates of the American Medical Association some two years ago, the Board of Trustees of the American Medical Association appointed a Council on Physical Therapy. This Council consists of a number of very high-grade men, scientists, physicists, clinicians, and others, and the purpose of the Council is to investigate the various physiotherapeutic agents that are offered for sale and to give a report which will furnish us a scientific basis for this work.

It seems to me that it would be well for all of us to watch carefully for the reports that come from this Council as they become available. I think then we shall have some information that will be scientific, impartial, and non-commercial, something upon which we can depend.

Dr. Edward Evans (La Crosse): I wonder if it would be interesting to the profession in Wisconsin to know that one of our largest insurance companies, engaged in the field of employers' liability, forbids anybody on its panel to use diathermy or actinic rays or any of those methods here discussed without authorization from the central office. This has come about, I believe, because of the great abuse of those agents.

I should like to ask Dr. Pope what he would suggest be done about it.

Dr. A. W. Rogers (Oconomowoc): I was very much surprised, during Dr. Pope's address, which was certainly edifying and most eloquent, that he made no reference whatsoever to the psychic effect of the various treatments which he described. For probably thirty years I have been using most of the apparatus that I felt there was any value in, but after this number of years I have pretty much reached the conclusion that the psychic element, the element of suggestion, is of equal importance to the real mechanical and physical and chemical effects.

I should like to hear him make some comment on that.

Dr. Curran Pope (Louisville, Ky.): Mr. President, in answer to my good friend, Dr. Elsom, I will plead guilty. Down in Kentucky we Kentuckians had an idea, or we did have in the good old days, that the sun shines just a little bit brighter and the streams roll along a little bit merrier, that the pebbles are smoother in the brook; that we have the fastest horses in the world and the most beautiful women, and we did have the idea that we had the finest whiskey, but it was a settled and established custom to use water—after it. (Laughter.)

If any of you have read any of the many articles that I have been guilty of imposing upon the medical profession, you will know that I consider physical therapy as one of the forms of therapy, but that in my practice I employ every form of therapy, and in my articles I nearly always speak of the other therapy first and physical therapy last. It is valuable, but it is no more of a special therapy than is iron or arsenic or quinine or mercury. These are adjuvants, handmaidens, and so are the various measures of physical therapy.

I have practiced medicine and physical therapy a long time. I came in in 1889. I was a student of the great Winternitz in Vienna just when he was publishing his wonderful scientific investigations that placed hydrotherapy on a scientific foundation from which it never could be shaken and never has been shaken. I have

lived to see demonstrable proof of the physical value of these remedies.

In answer to the Doctor, I will ask where in medicine will you get away from psychology and suggestion? Where in medicine and surgery do you want to get away from it? The man in medicine who does not practice it all the time, does not subtly emanate it from himself in manner, in action, in word, is a loser. He doesn't know his business. He may be doctoring, but he is not doctoring one hundred per cent. Everywhere we turn in this world you influence me and I influence you when we come in contact. There is a psychic reaction from which you cannot possibly get away.

Remember, I am a neurologist and an internal medicine man, and I practice psychology all the time, but you can't get away from the physical facts that you can see. Take two wires, connect them with either side of this deified diathermy, take up a little piece of meat and put it between them, turn on just a little bit of current. If that were human tissue you would cut it right straight off without bleeding. It beats the clamp and cautery a thousandfold in taking off a hemorrhoid. Put a hemorrhoid in the diathermic clamp, cauterize it through and through in three seconds, take off the cord and attach it to the knife and with one sweep smooth off the top of it, and you have the cleanest, the best operation that can be performed for the removal of hemorrhoids.

Take two eggs and put the whites in a flat dish, attach two small round metal electrodes to the high frequency machine, embed them in the white of the egg, and in a little while you will find white flakes coming from the sides of the electrodes until they connect; you have boiled the egg from one edge to the other, and all the psychic suggestion and all the influence on this earth upon the egg or any other thing that is developed from the egg could not stop that. (Laughter and applause.)

Take a long, slender potato, put a pad at either end, and bake it from the inside out. Take a piece of meat, stick a copper needle in it, put another pad on the other side of it, and diffuse your copper salt all through that meat from your galvanic positive pole. You can do that in the uterus and you can carry it into the glands, and if you put mercury, quicksilver, on that electrode, you have your oxychlorid of mercury and copper, the most powerful antiseptic known, that will more quickly destroy a gonorrheal infection than anything on earth that I know of, and I will let anybody stand by and suggest to the contrary until the crack of doom. Those are visible, demonstrable, provable entities, absolutely, psychic states to the contrary. With all the will power in your mind and soul and body you can't stop your arm from responding to the faradic current or the galvanic current. I can put a pad on your abdomen, and all the will power on earth can't keep your hair from standing up and vibrating when activated by the static wave current.

Have you ever seen a bad sprain? Why are all of you ashamed to touch a patient with your hands? That is where the "practors" and the "paths" get in. Have you ever taken a swollen joint, an ankle, and put it on your lap and very gently worked that joint and manipulated it until before you got through, in ten or fifteen minutes, most of the swelling was gone?

Dr. Douglas Graham, of Boston, gave me the surprise of my life when a patient came in on two crutches, and after massage walked out alone with a cane.

Have you ever had a fever and been sponged with cold water? If you haven't you don't know what is real comfort. Today I owe my very life and existence to hydrotherapy. I had a very severe septic infection in my arm. The continuous bath, the cold sponging, relieved me very promptly, and yet you cannot get surgeons or physicians to do these things that will give infinite and oftentimes immediate relief. But the psychic element remains all the same. It cannot do certain things, though. It can go so far and no farther.

If the gentleman will pardon a personal remark, I will cite these two instances of the men who got up and stated their own cases about so-called high blood pressure. They offered themselves as the *enfant incorrigible*, so they will pardon me. Do you know why both of them are getting along so well? Neither one of them is afraid. They have eliminated fear. They have habituated themselves to an idea. They have learned to live with it, and that is hard on the undertakers they mentioned. There is an instance where psychology is of great value, and so it is in every case. I try to sway and control and influence every human being that comes under me, I try to influence them and urge them in the right direction, but I don't forget for one minute what my physical remedies will do in a physical and material way. I try to scramble the eggs. (Applause.)

PNEUMONIA FROM PUBLIC HEALTH POINT OF VIEW

C. J. Vaux, Pittsburgh (Journal A. M. A., Dec. 11, 1926), describes the steps taken by the Pittsburgh Department of Health since April, 1924, in the prevention of pneumonia. The death rate for the first eleven months of 1923 was 319 per hundred thousand. For the same period in 1926, it was 168. In Pittsburgh, the regulation covering reports of cases of pneumonia is: "Pneumonias (all forms) are reportable diseases in the city of Pittsburgh; specify (a) lobar pneumonia; (b) bronchopneumonia; (c) pneumonia complicating influenza; (d) pneumonia complicating other communicable diseases; (e) all other pneumonias, as traumatic, anesthetic, senile, etc.; specify whether lobar pneumonia or bronchopneumonia in all of the above primary conditions." Actual quarantine in certain types of cases is optional with the department of public health; also, the quarantine regulation is a modified quarantine, as follows: "Modified quarantine will be enforced in all cases of pneumonia, except that under the classification e ('all other pneumonias, as traumatic, anesthetic, senile, etc.') may be quarantined at the option of the department of public health. This modified quarantine will consist of placarding, isolation of the patient, prohibition of all visitors, but no restrictions on other members of the household, including school children, provided isolation is complete and instructions from the department of public health are properly carried out. No minimum number of quanantine days specified, the quarantine period being until recovery or death of patient." Complete sanitary cleaning of the premises is required before release, but, when this is accomplished thoroughly following the physician's report of recovery, quarantine release is made at once. In a fatal case, after sanitary cleaning, no funeral restrictions are made. Regulations governing pneumococcus carriers or laboratory release regulations were not incorporated. There has not been a single complaint regarding the pneumonia quarantine regulation by either a lay citizen or a physician since it was put into effect, April 1, 1924.

PREVENTIVE MEDICINE

W. D. STOVALL, M. D., Editor

Health Activities in Communities Without a Full-Time Health Department

BY W. D. STOVALL, M.D.
University of Wisconsin
Madison

Specialization in the field of Public Health is as necessary and more frequent than in the field of clinical practice of medicine. Effort for the conservation of human life is not confined wholly within the capabilities of the medical profession but draws upon many branches of various sciences. The prevention of disease is not purely a problem for the medical profession but requires the services of engineers, biologists and others who are experts in the branches of science which may be applied for the prevention of disease. A striking example of how the field of public health has broadened to the extent of requiring specialists of many kinds is revealed in the development of one department.

Prior to 1890 communicable disease control was based entirely upon clinical practice. No certain methods by which to make rules for isolation and quarantine were available. These were made upon the majority opinion among physicians concerning the period of infectivity of people suffering with these diseases. Methods of disinfection were based on terminal fumigation without regard to concurrent disinfection. The scales from scarlet fever were considered to be infectious, and the length of quarantine was naturally extended until desquamation was over.

Now the practice is entirely changed. Rules for the control of communicable diseases are the result of knowledge concerning the biology of the etiologic agent of these diseases. The length of infectivity of the patient is dependent upon the length of time he continues to harbor pathogenic bacteria. The length of isolation or quarantine is, therefore, based not on the result of physical examination but upon the result of a bacteriological study of the body excreta or diseased tissue. Fomites are not considered as of great importance in the spread of disease and the vigilant practice of concurrent disinfection is regarded as of more importance than terminal fumigation.

These changes in public health practice have been brought about because of the development of bacteriology. The health officer can no longer practice public health alone. He must be assisted by a competent bacteriologist. His quarantine and isolation periods are based on bacteriological findings and in order to enforce them bacteriological methods must be used. This requires specialization on the part of the individual and employment of special equipment. The laboratory has become a necessary division of all health departments not alone for its importance in communicable disease control but for the aid it gives in many other branches of health activity. This represents but one of the large fields which have developed in recent years. There are many others among which are sanitary engineering, school medical inspection and child welfare, which includes the development of clinics for the care of school and pre-school children where they receive among many other things specific immunization against certain of the communicable diseases.

The whole significance of this is that just as the field of medicine has broadened to the extent that it is desirable for physicians to specialize and practice together in groups, so public health has broadened until its proper practice means the employment of a number of different kinds of specialists. This, of course, is expensive. The physician in private practice has met this economic crisis by organizing clinics and reducing overhead. The higher units of the government have been able to secure for health departments the specialists required because of the size of the population from which their budgets are secured. The larger cities have for the same reason been able to meet this demand. But what has happened to the smaller cities and rural communities? They cannot secure money enough, without inflicting hardships on the community, to secure all the essentials of a well organized health department.

They, therefore, must depend upon an organization which is not part of their community organization, the state government. It is obvious that the State Health Department cannot have a personnel large enough to give attention to all of the health needs of every community.

In a recent article Dr. Bauer outlined what he considers the bare essentials for a small health department where a complete organization is not possible. He gave these as a part-time health officer, who must be a physician, a clerk, a sanitary inspector and quarantine officer and a public health or school nurse, the last three to be employed full time and have a definite office. The State Board of Health under such a scheme would be able to supply the assistance needed from highly specialized experts.

While it is true that the scope of Public Health practice goes beyond the purely medical problems of a community, still many of the problems are purely medical, and for that reason a physician is a necessary member of every health organization. Without expert medical advice it is probable that the largest part of a health board's activities can not be scientifically applied. In the smaller unities of government the community medical problems are the ones which are most pressing for solution and require the attention of physicians who are located permanently in the community. Without the hearty cooperation of the local physicians no community, and especially a small one, can accomplish school medical inspection, control of communicable diseases or the establishment of pre-school or child welfare clinics.

CHALLENGE TO COUNTY SOCIETIES

These problems, it seems to me, are a challenge to the medical profession and deserve the attention of both state and county medical societies. It is their opportunity to assume leadership in this phase of community welfare which is properly their field. I think the county societies or the local physicians in Wisconsin should make it their public health policy to aid in the organization, with the advice of the State Board of Health, of health departments adequate to meet the needs of their communities.

Last year the Wisconsin Conference of Social Workers asked me to outline for them a public health program for the year. My suggestion was the organization of clinics for the medical examination of pre-school children in cities where the health department is not sufficiently organized to meet this need. I gave them a plan to operate by, which was recommended to the House of Delegates at the last meeting of the State Medical Society by the Committee on Health and Public Instruction. The plan follows:

"A plan for the development of pre-school clinics through the cooperation of the state and county medical societies, the State Board of Health, the local health departments and local health committees.

"1. The State Board of Health will organize and run the first clinic held in the community. They will recommend standard procedures. This will include types and methods of examination, record forms, and follow-up work.

"2. The local medical society will be acquainted with the plan, and asked by the local health committee to name a member of the local society to take charge of the clinic. The man selected should be a young man whose practice is not yet so large as to occupy the whole of his time and one who has an interest in diseases of children. He should spend time with the State Board of Health physician during the time that the first clinic is conducted. This will thoroughly acquaint him with the methods to be used and the plan under which the clinic is to be organized. This selection by the local society should be for as long a period as the member selected will serve. There should be no rotation of service in the clinic. This would mean divided responsibility and eventual demoralization with a consequent failure of the scheme. The physician should receive reasonable compensation for the time he works. The money to meet the expenses of these clinics will be raised in the city by any method which the local Health Committee deems advisable."

This scheme is suggested because it not only provides for the participation of the local medical society in the solving of the medical problems which are of community importance, but because it also provides the locality with a permanent clinic which is its own.

Such a scheme would also insure standardized clinics throughout the state and the data gathered would have tremendous value for statistical studies.

With the continued increase in the necessity for various kinds of specialists in the field of public health the probability of securing a complete staff

and necessary equipment for a fully organized health department except by large cities and in the higher units of government, state and national, seems remote. There are not now enough trained health officers in the country to attempt the organization of a complete health department in the counties in any state to say nothing of all the states. This may be an ideal to strive for but in the meantime our problem is unsolved and nothing is being done about it except the effort which the State Board of Health is making to bring health administration into every community. This effort is large and praiseworthy but many of these needs are too individual for any outside agency to completely satisfy. The plan has the added advantage of being most economic for the state could supply through its present organization the specialized workers for advice and consultation while the local machinery would carry on the every-day routine duties.

THE JOURNAL CLINIC

Lumbar Sympathectomy by the Abdominal Route in a Case of Raynaud's Disease

BY E. H. MENSING, M.D., AND J. O. DIETERLE, M.D.
Milwaukee

The patient, a farmer and rancher, aged 32, was admitted to the National Military Home Hospital at Milwaukee on April 5th, 1926. He is a widower.

Father died of carcinoma of the larynx at the age of 45. Family history is otherwise unimportant.

His past history reveals the usual diseases of childhood, with good recovery. In November, 1916, he submitted to an amputation of the distal phalanx of the left thumb, which was injured in a clothes wringer, when a child. There is no history of other important illnesses, traumatisms, or operations.

His present trouble dates from military service during the World War. In November, 1918, while in the Argonne he suddenly experienced severe pain in both feet and the toes. The ends of the toes became deep purplish in color and later some of them became black. He developed sloughing of the skin at the tips of the toes. Feet were cold to the touch and he experienced severe pain in both feet, referred up the legs. After three days he was sent to a base hospital at Vichy, France, where he was given treatment, consisting of hot applications. He remained in bed for two months and was sent back to the States unimproved. While at Camp Grant during March, 1919, he had a recurrent attack of the cyanotic condition of the toes. This condition cleared up temporarily and he was discharged from Camp Grant in the same month. In July, 1919, while at Salt Lake City, Utah, the trouble recurred and an amputation of the middle toe of the left foot was performed because of ulceration. Patient then returned to Racine, Wis., where he had the second toe of the same foot amputated for the same reason. After a stay of four months in the hospital, he attempted to do farm work, but was forced to abandon this on account of severe pain in both feet and persistent ulceration of the toes. Patient then went along with periods of improvement and exacerbations until 1924, when he entered the Speedway Hospital at Chicago for the same trouble, where conservative treatment was of no avail. In the fall of 1925 he tried work on a ranch near Omaha, but again severe foot pain forced him to seek relief at the Speedway Hospital. In April, 1926, he entered the National Military Hospital at Milwaukee, complaining of severe knife-like pains in both feet. Patient was kept in bed and given symptomatic treatment until August, 1926, when after a consultation, it was decided to extirpate the lumbar sympathetic chains by the abdominal route, as a last resort.

On August 3rd, 1926, patient was operated upon by Dr. E. H. Mensing of the Surgical Staff. Ether anesthesia was used; patient placed in Trendelenburg posture. A long median abdominal incision was made from the umbilicus to the bladder. The intestines were walled off with hot packs, properly placed. After careful retraction of the right ureter to the right and the inferior vena cava to

the left, the right lumbar sympathetic chain was exposed by incising the parietal peritoneum overlying the lateral aspect of the lumbar vertebrae. The entire chain, including four ganglia, was resected. Some difficulty was encountered in mobilizing the vena cava on account of lateral branches, which had to be ligated. The exposure, by use of packs, was difficult and somewhat unsatisfactory. In removal of the chain on the left side, the intestines were displaced from the abdominal cavity and kept retracted under hot packs. This exposure was much more satisfactory, and after isolation and retraction of the left ureter and the abdominal aorta, the left chain was easily exposed and removed. No attempt was made to repair the rents in the parietal peritoneum. The abdominal incision was closed in the usual manner. The convalescence has been uneventful and it is interesting to note that for the first time in eight years this patient states he is entirely relieved of pain in the feet.

The sensation of warmth has returned to both feet, and but for the very tips of some of the toes, the feet feel warm to palpation. It is four weeks since his operation and as no pain has returned to date, this bids well to be a complete symptomatic cure of a very painful, long-standing condition, which resisted all forms of medical treatment.

Open Safety Pin Swallowed by Child Twenty Months Old; Case Report

BY J. O. McCRACKEN, M.D.
Kenosha

On October 21, 1926, Baby A.-S., 20 months old, was observed by her mother to be partially choking and upon investigation the mother saw a safety pin in the child's throat. She tried to get the pin out but it passed on down out of sight. Dr. J. O. McCracken was called to attend the child. The doctor found an apparently healthy, well nourished child of normal size and appearance. As there were no objective nor subjective signs of trouble, it was decided to make an x-ray examination to determine whether or not a pin had been swallowed and if so its location and position with regard to the anatomical organs of the child's body.

Fluoroscopic examination by Dr. Perry discovered presence of a medium sized, opened safety pin in the child's esophagus on a level with the superior extremity of the sternum. The safety pin was lodged with the open end upward and the curved spring end of pin projecting downward toward stomach. As a matter of record, the roentgenogram shown as Figure 1 was then made.

After a consultation the physicians decided that inasmuch as the child was apparently not suffering, and, owing to the dangerous location and position of the open pin, it would be best to wait for a few hours for a possible change of position so that it might be safely removed with the aid of the esophagoscope.

After twenty-four hours of expectant waiting, during which time fluoroscopic examinations were made, it was found that the position of the open safety pin remained unchanged and that it was still located as shown in Figure 1.

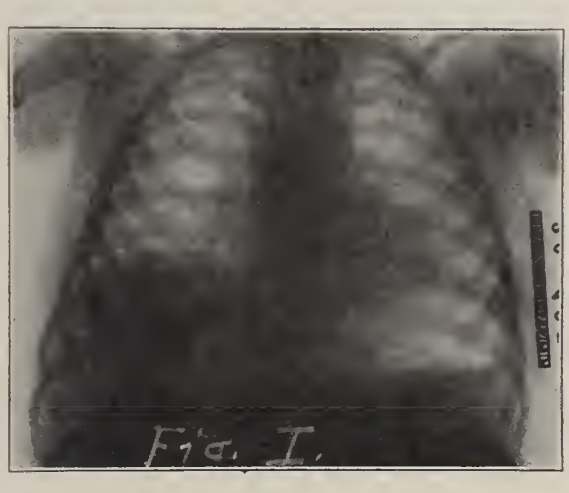

Fig. 1.

Fearing a possible traumatic ulceration of the esophagus if the pin were allowed to remain in the same position for a longer time, Dr. McCracken had the child taken to the clinic of Dr. T. W. Ashley. By means of his esophagoscope, Dr. Ashley could see the pin in the location and position shown by the previous x-ray examinations. As an attempt to pull the pin upward by means of forceps would be quite likely to cause a perforation of the esophagus, the doctor tried to close the open safety pin by means of his special instrument (pin-closing forceps) but the swollen mucosa lining the esophagus prevented this being done.

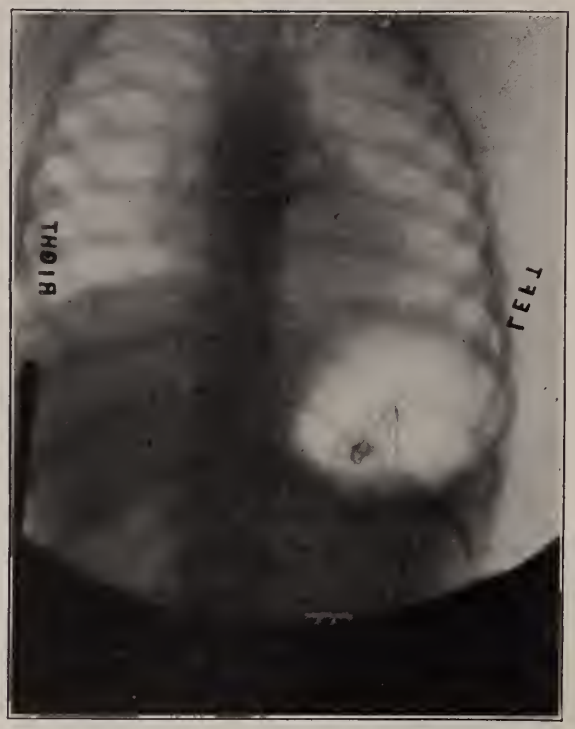

Fig. 2.

It was then decided that the most safe procedure to follow and the treatment that would be most likely to save the child's life, would be to push the pin on down into the child's stomach while the child was still under the influence of the general anesthetic. Dr. Ashley then proceeded to push the pin on down into the baby's stomach and left it in the position as shown by the roentgenogram marked Figure 2. It was then decided it would be best to again await further developments before resorting to any further operative procedures, and Dr. Perry was requested to make occasional x-ray observations to determine the progress of the case.

In the meantime the child was placed upon a diet of starchy gruels of liberal amount, with the idea of dilating the bowel by both the presence of the liquids and of the gas resulting from the starch digestion.

About thirty hours later the child passed the open safety pin per rectum without any especial discomfort. The pin was 7/8 of an inch long and measured 5/8 of an inch between the open ends. The child has ever since been in apparently perfect health.

Two quite similar cases have occurred in this city recently and in both of which serious surgical procedures were resorted to with the result that one of the children died and the other one had to necessarily undergo a considerable period of convalescence. In view of the further fact that cases of this nature are somewhat frequent and the mortality rate high, it was decided to publish the details of this case.

Abstract of Papers Before University of Wisconsin Medical Society

C. D. LEAKE, EDITOR

THE GENERAL PRACTITIONER IN MEDICINE

BY EDWARD EVANS, M.D.
La Crosse

Editor's Note: This is an abstract of the first of a series of talks on the practical aspects of the physician's work, to be given by members of the preceptorial staff of the University of Wisconsin Medical School.

The general practitioner is the most important single individual in medicine; he sees the majority of sick people, maintains the closest personal contact with them, and is the first to initiate treatment and to deserve their gratitude and thanks. The general practitioner at the present time is able to have in his own office ninety per cent of the facilities of most specialists. For a very small sum, he can have all the technical instruments necessary for even complicated diagnostic examinations, including the microscope, an x-ray apparatus, and chemicals and dyes. Furthermore, the advantages of easy communication and good roads make it possible for him to serve an ever increasing number of people and, by pooling his interests with others in a clinic, to give the highest sort of medical service to a large rural community.

It is wrong to consider a general practitioner in the light of the old-fashioned country doctor. Modern conveniences have made it possible for the country doctor to perform the highest kind of medical service. Furthermore, his opportunities for maintaining contact with leaders of the profession have been greatly improved through technical journals and new advantages in post graduate instruction.

As a result of forty years' experience as a general practitioner, many little points of interest have developed. Some of these refer to details of

technical practice and others to the more general aspects of the profession.

In the first place, with regard to details of medical practice. One of the most serious handicaps to success, as a general practitioner, is physical laziness. Failure to make a correct diagnosis and to institute proper treatment is frequently due to this defect. It is necessary to make a personal, complete and careful examination of the patient. In general practice, one must always keep in mind the possible presence of syphilis. This is becoming increasingly prevalent in the rural districts. The Wassermann test in this connection should be employed chiefly to confirm the diagnosis. In handling a patient, it is most important to investigate and keep in mind the general physical condition. This is especially true in regard to pneumonia.

Probably the most important detail in general practice is the keeping of careful and accurate records. A good history is of great aid in forming a proper diagnosis and records should be systematically and conscientiously kept. This encourages care and deliberation in regard to forming an opinion concerning a patient and promotes a valuable mental habit and discipline.

There are, in general, three classes of physicians: First, those who honestly are following their calling of treating and aiding the sick but without imagination or without ideals. Secondly, there are the money seekers, the craftsmen, and the business men who really have no place in medicine at all. Thirdly, there are the idealists who have a high conception of the profession of medicine, its obligations to society, and its great possibilities for scientific service. These are the men who combine, in the rare way, science and art in the practice of medicine, maintaining themselves scientifically alert and humanly sympathetic.

To assume a position as a specialist in medicine implies, in the first place, a broad knowledge of all medicine and, secondly, a greater knowledge than any one else about some particular phase of medicine. This is an assumption which few should dare to make.

There is, finally, a duty to the profession owed by the general practitioner. The basic unit of the profession, which is the local medical society, requires the support and interest of the practitioners of the community. Active interest will, in the long run, tend to uphold the dignified position and honor of the profession. By combining common sense with common honesty, the new recruit to the general practice of medicine will find that his way will be comparatively smooth. One cannot do better than adhere to the principles of the Hippocratic oath. On the members of the class of 1927 of the University of Wisconsin Medical School rests a great responsibility; they are to become the first fruits of a new experiment in medical education in which the ancient preceptorial system is being applied in a modern way. Their activities will be closely observed.

SWIMMING POOL SANITATION

BY W. D. STOVALL, M.D.

Laboratory of Hygiene, State of Wisconsin

The possibility of acquiring communicable diseases from bathing in swimming pools is a debated question in medicine. There is no doubt, however, of the danger of acquiring disagreeable skin diseases from unsanitary pools. It is also undoubtedly true that contaminated water may contribute to the incidence of upper respiratory infections and also to irritation and possible infection of the eyes and ears. The question of swimming suit sanitation merits special attention.

Up to within ten years ago, it was the custom in handling a swimming pool to change the water about once a week and to drag cans of chlorinated lime through the pool twice a week. These measures resulted in deodorizing the room somewhat but hardly were effective in keeping the water in the pool sterile. Studies were made with Dr. M. Starr Nichols and Miss Vera E. Vincent on the effects of treating swimming pools with copper sulphate or with sodium hypochlorite. It was found that bi-weekly treatments with copper sulphate caused a slight fall in the number of bacteria estimated by plate cultures from the swimming pool water. Hypochlorite treatment actually resulted in a higher bacterial count than untreated water, probably due to the fact that the resulting decomposition of organic material gave more food to the bacteria. Continuous filtration of the water in the pool was tried in order to ascertain whether or not filtration is sufficient to render chemical treatment unnecessary. Continuous filtration at the rate of 1,000 gallons an hour was found to reduce the bacterial count by 25 per cent. It was then found that if the filtered water was treated with a liquid chlorine preparation, the pool could be made

(Continued on Page XXII.)

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SERVICE AVAILABLE

There is listed the following definite services that are available to our readers—the members of the State Medical Society of Wisconsin. If you have a need not covered here address the Secretary, Mr. J. G. Crownhart, 153 Oneida Street, Milwaukee. "Let George do it."

FOR THE MEMBER

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FOR THE COUNTY SOCIETY

1. *Program Material.* Pursuant to authorization by the 1924 House of Delegates the Secretary is arranging to make program material available without cost. The following can now be secured:

A. Departmental Officers of the State Board of Health. Address Dr. C. A. Harper, State Health Officer, State Capitol, Madison, Wis.

B. Clinicians of the Wisconsin Anti-Tuberculosis Association when in vicinity. Address Clinic Dept., W. A. T. A., 558 Jefferson Street, Milwaukee.

C. Councilors and Officers of the State Society. Address the individual.

2. *Annual Statements.* Uniform annual statements can be had without cost. Address the Secretary, advising number desired.

EDITORIALS

LAW ENFORCEMENT

TWENTY years ago this Journal editorially declared that laws governing those who may treat the sick "should and must be enforced."

The duty and responsibility for the enforcement of these laws is vested in the regular law enforcement officers of the state and with the State Board of Medical Examiners. During the year past this Board has studied the law enforcement problem as it exists today. The Board has announced a course of action. It has made certain requests of the organized profession of the state which, in all but one respect*, have been accomplished together with an emphatic endorsement of the announced program.

With a meeting of the Board this month we believe it timely again to pledge our moral support and our active support where it may be considered helpful to accomplishment of the end in view. We assure the Board that we realize that they have problems to solve, courses of action not always easy to determine. That these difficulties will not be insurmountable we feel sure and express the hope of their brother practitioners that this announced campaign, once started, will be a continuous one.

As we declared in 1906, our laws should be so enforced as to "guarantee to the sick that when they call for the services of a man who holds himself out as a physician, they shall at least have the services of an educated man and one who conducts his practice along the lines of ordinary decency and common honesty. That is all the profession asks for and the least the public should expect."

AN EPOCHAL DEPARTURE

WITH the building of the Wisconsin General Hospital as a Service Memorial on the university grounds at Madison, it became possible to add the third and fourth clinical years to the first and second years of medical study which had been established for some years. Last year the third year was given and the students of this third year class are now continuing their final year at Madison. With the establishment of a full four-year course the university has been able to put into operation a method of teaching which, I believe, marks an epoch in medical education. The fourth year of the medical course will extend over 48 weeks. During this period students will spend about half the time at the Wisconsin General Hospital and half the time in extra-mural service. In this extra-mural service small groups of from one to three students work under the supervision and direction of extra-mural preceptors. The extra-mural preceptor is responsible for the instruction of the students under his supervision during the period the students are assigned to him; he prescribes and directs their studies, and is responsible to the faculty of medicine for these students, and reports to the proper committee of the medical faculty as to their progress and ability. Each student is assigned to one service extending over three months and of several shorter services.

This departure is sure to be watched with a great deal of interest by the medical profession and especially by the teachers of medical schools. Many members of the medical profession feel that the medical student is too long in leading strings; that it should be possible to have a method of teaching that would not only qualify the student as a safe and scientific practitioner, but that would also qualify him through social contacts and work in the environment of private practice, to make a better rounded medical man. There can be no doubt that even the best trained graduate, so far as the science of medicine is concerned, is on graduation, woefully lacking in the art of medicine and the proper handling of private patients.

This departure in medical teaching should have a very stimulating effect on the hospitals and their staffs where these students work. The staff will be under constant observation of bright, well trained students, critical in their attitude and quick to notice short-comings, either in proper investigation of patients or careful recording of the conditions observed. This will cause a healthy competition and be a stimulus to the various centers to which students are sent. It will thus inevitably improve the standard of medicine in those centers and in the territory about. It is

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*A suggestion that additional funds would be helpful is still under consideration.

hoped that, as the plan is developed, other centers qualified to teach those students will be added to the list now designated until the whole state of Wisconsin is covered with extra-mural teaching centers.

This plan demands that the student be of a high type and that the fourth year class be limited in numbers on the basis of intelligence and scholarship. It requires also that those taking the responsibility for training students will give them more than passing attention. The preceptor must be prepared not only to prescribe reading and investigation, but also to give time to supervise such work as is prescribed. The supervision in each instance will fail in great degree if he does not enlist the sympathetic cooperation of every member of the hospital staff, qualified by training and enthusiasm to assist in this teaching.

There can be no question as to the success of this plan if all concerned enthusiastically support it.—*E. E.*

THE SENSE OF SMELL IN DIAGNOSIS

THE five senses with which we are endowed vary markedly in sensitiveness in different individuals. In our evolutionary development sight and hearing have become most acute. Occasionally in the blind the sense of touch is so highly trained that it takes the place of sight for objects that can be felt. It is common knowledge that animals gather much of their information through the sense of smell. The center in the brain, the gyru hippocampus, is well developed. In the human brain this center has undergone marked reduction in size as the result of disuse through untold ages. Yet we still have a sense of smell which in some people is more acute than in others.

Scattered throughout medical history are allusions to the peculiar odor which certain diseases have. The older physicians will tell of the characteristic odors of diphtheria, of smallpox, of typhoid fever, and other diseases. The victim of tuberculosis has a peculiar odor which is noticeable to the person with a sensitive nostril. In fact people sometimes volunteer the information that they have noted since they have begun to feel ill, that there is a pungent, disagreeable odor of their bodies most intense in the axillae. Many times nurses have diagnosed typhoid fever before the signs and symptoms were outspoken, by the musty, mousey smell of the patient. Years ago when remittent malaria and typhoid fever were lying in the same ward with patients presenting symptoms quite similar and diagnosis at times uncertain, the fellow with the keen sense of smell was able to make the diagnosis.

In our search for new methods of diagnosis we frequently overlook small helps which were well-known to the older physicians. Not so long ago Chvostek of Vienna in a clinical lecture bemoaned the fact that physicians were neglecting to use one of their senses in diagnosis. Recently Hauffe, writing in "Medizinische Klinik," Berlin, relates the case of a physician who, becoming blind, was able to differentiate measles from scarlet fever by the odor of the patient.

Many years ago the writer became convinced that not only did the case of advanced tuberculosis have a peculiar and distinctive odor, but the very early case had the same odor. In talking with men who were specializing in tuberculosis he found some who agreed with him and some who scouted the idea. It is difficult to convince some one else of the presence of distinctive odors because odors are frequently difficult of objective description so that others can appreciate them, and people vary so much in their ability to differentiate odors. To say that an odor is foul or pleasant, pungent or acrid, agreeable or disagreeable is about all one can say. What is agreeable to one may be disagreeable to others. Possibly the difficulty of accurately describing odors has led to the neglect in the use of them as an aid in diagnosis. However, there seems to be enough evidence to be able to say quite definitely that certain diseases do have distinctive odors.

Because some cannot recognize and differentiate these odors is no argument that they do not exist. It indicates either that the skeptic has an insensitive nostril or that he has neglected to train his sense of smell as he has trained his other senses. We no longer use the sense of taste to determine the presence of "sweet urine."

Sight, hearing and touch are the senses which we attempt to train. Very likely in our intensive search for finer methods of diagnosis we have neglected to make the fullest use of one right under our noses, so to speak.—L. M. W.

THE PRESIDENT'S PAGE

Arthur W. Rogers

NECESSITY FOR ORGANIZATION

We take it that the establishing of the President's page was for the purpose of concisely setting before the medical profession of the state matters of vital interest and importance, and to stress those things which we feel desirable to call to your attention.

At this time we wish to emphasize the need and value of greater and closer organization. Conditions are continually changing, and we sometimes fear that the ultra-conservatism of the medical profession prevents it from always keeping abreast of the times. At a time when the authorities at Washington have passed from a disposition to discourage and even legislate against combines and organizations, to actual encouragement along these lines; at a time when any group of individuals desirous of putting over any special movement finds it necessary to combine and organize, it behooves us with worthy projects to do likewise. We have in our parent organization, the A. M. A., a wonderfully efficient group, and most of our state societies are well organized; but many of our county societies are too loose-jointed to function properly. The county society is the unit of the state organization, and if the majority of the county societies are not functioning well we cannot expect a strong state organization.

We should sense the need of electing to office men who are willing to give some time and thought to their official duties. This is especially true of the county secretary. He is the one to keep in close touch with the activities of both national and state societies, and keep the members properly informed; to provide programs which will attract large attendance, and to keep the delinquents in line. Organization has its natural beginning in the county society unit.

The district medical meetings, so successfully conducted during the past year, will be continued, since they are a means of cultivating closer acquaintanceship and friendship, and are a stimulus to more concerted action.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

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Barron-Polk-Washburn-Sawyer-Burnett	H. M. Coleman, Barron	D. L. Dawson, Rice Lake.
Brown-Kewaunee	F. J. Gosin, Green Bay	F. M. Harris, Green Bay.
Calumet	J. A. Schmidt, Brillion	H. C. Krohn, New Holstein.
Chippewa	C. B. Hatleberg, Chippewa Falls	W. C. Henske, Chippewa Falls.
Clark	F. D. Jackey, Thorp	F. P. Nels, Thorp.
Columbia	A. F. Schmeling, Columbus	H. E. Gillette, Pardeeville.
Crawford	J. J. Kane Prairie du Chien	C. A. Armstrong, Prairie du Chien.
Dane	Louis Fauerbach, Madison	Hans H. Reese, Madison.
Dodge	L. M. Bachhuber, Mayville	A. A. Hoyer, Beaver Dam.
Door	John Hirschboeck, Forestville	T. C. Proctor, Sturgeon Bay.
Douglas	V. E. Ekblad, Superior	E. E. Carpenter, Superior.
Eau Claire and Associated Counties	G. W. Beebe, Eau Claire	H. M. Stang, Eau Claire.
Fond du Lac	M. M. Scheid, Rosendale	D. N. Walters, Fond du Lac.
Grant	E. C. Howell, Fennimore	M. B. Glasler, Bloomington.
Green	J. L. Fleek, Brodhead	J. F. Mauermann, Monroe.
Green Lake-Waushara-Adams	Orvil O'Neal, Ripon	H. A. Schulz, Ripon.
Iowa	A. D. Brown, Mineral Point	M. W. Trentzsch, Highland.
Jefferson	W. C. Becker, Watertown	A. C. Nickels, Watertown.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	W. C. Stewart, Kenosha	H. A. Binnie, Kenosha.
La Crosse	Sigurd Gunderson, La Crosse	N. P. Anderson, La Crosse.
La Fayette	W. W. Peck, Darlington	S. A. J. Ennis, Shullsburg.
Langlade	M. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	E. K. Morris, Merrill	W. H. Bayer, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	M. P. Andrews, Manitowoc.
Marathon	E. M. Macauly, Wausau	J. M. Freeman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	M. D. Bird, Marinette.
Milwaukee	S. J. Seeger, Milwaukee	E. L. Tharinger, Milwaukee.
Monroe	H. B. Johnson, Tomah	H. H. Williams, Sparta.
Oconto	C. W. Stoelting, Oconto	C. J. Ouellette, Oconto.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schlek, Rhinelander.
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Pierce-St. Croix	Rolla Cairns, River Falls	J. W. Prentice, Deer Park.
Portage	G. H. Lawrence, Stevens Point	F. R. Krembs, Stevens Point.
Price-Taylor	E. A. Riley, Park Falls	J. D. Leahy, Park Falls.
Racine	H. B. Keland, Racine	Susan Jones, Racine.
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Rock	E. B. Brown, Beloit	G. K. Wooll, Janesville.
Rusk	L. M. Lundmark, Ladysmith	H. C. Johnson, Bruce.
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SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

Physicians and dentists of the Brown-Kewaunee County Medical Society and from the Brown County Dental Society gathered at the Crystal Ball Room of the Hotel Northland, Green Bay, on December 8th to hear Dr. C. J. Hollister, of Harrisburg, Pa., speak on the importance of good teeth in the individual to the health of the community. The city council, the board of education and the city nurses were guests of the societies at the dinner-meeting.—F. M. H.

COLUMBIA

The December meeting of the Columbia County Medical Society was held at the county asylum at Wyocena. Following the noon luncheon Dr. C. A. Harper of the State Board of Health, gave a talk on scarlet fever and on the examination of apparently healthy persons. Dr. Edward Tierney, Portage, presented a paper on "Uretral Stricture."

The following officers were elected for 1927: Dr. A. F. Schmeling, Columbus, president; Dr. C. W. Henney, Portage, vice-president; Dr. H. E. Gillette, Pardeeville, secretary-treasurer; Dr. Schmeling, delegate; Dr. Gillette, alternate, and Dr. Henney, censor.

A motion was put and carried to pay one-half the expense of the secretary to the Secretaries' Conference at Milwaukee in January, the State Society to pay the other half.—H. E. G.

GREEN LAKE-WAUSHARA-ADAMS

At the annual meeting of the Green Lake-Waushara-Adams County Medical Society, held at the Grand View Hotel, Ripon, on Thursday evening, December 9th, officers were elected for another year. Dr. Orvil O'Neal, Ripon, was chosen president; Dr. John Foat, Ripon, vice-president; and Dr. H. A. Schulz, Ripon, secretary and treasurer. A banquet was served at 6:30 which was well attended, the business session and discussions following.—H. A. S.

JEFFERSON

Falling in line with a suggestion from the State Society in regard to devoting at least one meeting a year to periodic health examinations, the members of the Jefferson County Medical Society secured Dr. Oscar Lotz, Milwaukee, to speak before them on this subject at their annual meeting and banquet held at the Elks' Club, Watertown, on December 16th. Mr. J. G. Crownhart, state secretary, spoke on "Some Present and Future Activities of the State Society."—A. C. N.

LANGLADE

The members of the Langlade County Medical Society met at Hotel Butterfield, Antigo, on Tuesday, December 14th. The session opened with a banquet, folllowed by a smoker and business meeting. Dr. M. J. Donohue, Antigo, was elected president for the ensuing year and Dr. E. F. Dorszeski, Antigo, was chosen vice-president. Dr. J. C. Wright, Antigo, will retain his post as secretary-treasurer and also as delegate to the state meeting, while Dr. J. W. Lambert, Antigo, will serve as alternate. Following the business session, George Crownhart, secretary of the State Medical Society, told of some of the past, present and future activities of the Society.

—J. C. W.

MARINETTE-FLORENCE

The members of the Marinette-Florence County Medical Society met at the Old English Grill, Marinette, on November 29th, and enjoyed a delicious turkey dinner. Dr. R. S. Cron, Milwaukee, gave an instructive paper on "Cervicitis and Version" which was illustrated by lantern slides.

Dr. T. J. Redelings, Marinette, will again serve as president of the society; Dr. H. F. Schroeder, as vice-president; Dr. M. D. Bird, secretary-treasurer; Dr. G. R. Duer, delegate; Dr. J. V. May, alternate, and Drs. J. W. Boren, S. Berglund, and M. D. Bird as censors.

The meeting was well attended, and there were guests from forty miles distant over a bad road.—M. D. B.

OUTAGAMIE

The regular monthly meeting of the Outagamie County Medical Society was held on October 26th. In the afternoon Dr. Donald T. Abbott, Chicago, conducted a clinic at St. Elizabeth's Hospital, Appleton. At this clinic five cases were presented and discussed. About twenty-five doctors attended this meeting.

Following a dinner at the Hotel Conway, Dr. Abbott gave a talk on "Colitis" which was illustrated by lantern slides. This talk was very interesting and instructive. The meeting was attended by about fifty physicians from Appleton and the surrounding territory.

The applications for Dr. W. E. Archer, Dr. Clarence Reed and Dr. R. R. Rivard were read by the secretary and upon motion were turned over to the Board of Censors. The transfer of Dr. Olin Paul was read by the secretary. This entitled Dr. Paul to membership in the Outagamie County Medical Society.

The November meeting of the society was held on November 16th. Dr. Arthur E. Hertzler, Kansas City, held a goiter clinic at St. Elizabeth's Hospital from 3:00 to 5:00 at which time fifteen goiter cases were presented and discussed.

In the evening following a dinner, Dr. Hertzler talked on "Goiter." The meeting was attended by about eighty physicians from Outagamie County and the surrounding territory. Dr. Hertzler's talk and clinic was one of the best we have had the pleasure of hearing.

Three new members were admitted to the society, namely, Dr. Clarence C. Reed, Appleton, Dr. Raymond Rivard, Little Chute, and Dr. W. E. Archer, Dale.

—E. L. B.

PORTAGE

Members of the Portage County Medical Society held their annual meeting at the office of Dr. G. H. Lawrence, Stevens Point, on Wednesday evening, December 8th. The following officers were chosen to serve for the coming year: President, Dr. G. H. Lawrence, Stevens Point; vice-president, Dr. H. M. Coon, Stevens Point; secretary-

treasurer, Dr. F. R. Krembs, Stevens Point; censors, Drs. W. F. Cowan, W. W. Gregory, and D. S. Rice. Dr. H. M. Coon was elected delegate to the state convention and Dr. F. R. Krembs as alternate. A paper on "Allergies and Anaphylaxis" was read by the newly elected president of the society, Dr. G. H. Lawrence.

—F. R. K.

ROCK

With upwards of one hundred and thirty-five members, wives, and guests present, the Rock County Medical Society held its annual meeting program at the County Hospital, Janesville, on Tuesday, November 30th. Dr. Rock Sleyster, Milwaukee Sanitarium, Wauwatosa, presented the scientific address at the afternoon session on "Nervous Disorders in General Practice." Dr. Sleyster concluded his address with a series of illustrative case histories which was followed by a general discussion.

Wives and guests were entertaind at cards in the afternoon while the scientific meeting was in session. Following the meeting a dinner was served in the large dining room which had been decorated to represent a winter scene. Following the dinner Dr. E. B. Brown, president of the society, presented Mr. F. F. Livermore, who gave a brief talk, and also introduced memorial resolutions in honor of the late Dr. J. F. Pember, Janesville, connected for a period of forty years with the county hospital. Other remarks pertinent to the occasion were given by Max Mouatt, Janesville attorney, J. G. Crownhart, secretary of the State Society, and Dr. Rock Sleyster, Wauwatosa.—G. K. W.

TREMPEALEAU-JACKSON-BUFFALO

At the annual meeting of the Trempealeau-Jackson-Buffalo County Medical Society, held at Galesville on November 10th, the following officers were elected for the year: President, Dr. George Christianson, Galesville; vice-president, Dr. G. F. Stack, Independence; secretary-treasurer, Dr. R. L. MacCornack, Whitehall; delegate, Dr. C. F. Peterson, Independence; alternate, Dr. H. A. Jegi, Galesville, and censor, Dr. John Lowe, Taylor.—R. L. MacC.

WASHINGTON-OZAUKEE

The members of the Washington-Ozaukee County Medical Society met in annual session at the Masonic Temple, West Bend, on Tuesday, December 7th. The President's Address was read by Dr. C. A. Balkwill, Grafton. Dr. Warren B. Hill, Milwaukee, presented a paper on "The Medical Aspect of Illegitimacy" and Judge F. W. Bucklin, West Bend, spoke on "The Legal Aspect of Illegitimacy."—A. H. H.

MILWAUKEE ACADEMY

Dr. L. M. Warfield and Dr. F. J. Gaenslen spoke before the Milwaukee Academy of Medicine on Tuesday, December 14th. "Thrombosis of Coronary Artery" was the subject of Dr. Warfield's address and Dr. Gaenslen spoke on "Diagnosis and Treatment of Osteomyelitis."

Doctors Carhart, Kaumheimer, Seaman and Stoddard have each added a number of books to the Academy Library and Dr. W. E. Grove has contributed an extremely large number of bound periodicals, covering eye, ear, nose and throat work and extending back a number of years. The Oto-Ophthalmic Society members are rapidly building up their section until it is becoming the most complete and up-to-date in the Library.

—D. E. W. W.

MILWAUKEE OTO-OPHTHALMIC

The regular monthly meeting of the Milwaukee Oto-Ophthalmic Society was held Tuesday evening, December 22nd, at the University Club. The meeting was preceded by dinner after which Dr. Robert Von der Heydt of Chicago presented a paper on "Slit-Lamp Microscopy." This was illustrated with lantern slides and Dr. Von der Heydt also demonstrated a number of photographs of the fundus oculi.—E. R. R.

WAUKESHA

The December meeting of the Waukesha County Medical Society was held on the first day of the month at 3:30 o'clock in the afternoon, at the Waukesha Springs Sanitarium, Waukesha. Following the election of officers, Dr. Louis F. Jermain, Milwaukee, presented a paper on "The Education of the Physician in the Matter of Periodic Health Examination." This address was followed by a general discussion.—J. F. W.

NEWS ITEMS AND PERSONALS

Dr. L. D. Quigley spoke to members of the Green Bay Gyro Club at a recent noon luncheon at the Beaumont Hotel on "Periodic Health Examination." He stressed the importance of a regular physical examination as a preventive of disease.

Dr. Quigley also gave a brief summary of all the diseases and their sources and concluded by saying: "I hope that I've convinced you that medical men are serious when they say that they would much prefer to work harder and keep you well than they would to do less work and be called to the rescue at times too late."

That the time will come when the state will extend its activities in the matter of public health perhaps even to the point of compulsory periodical medical examinations for all, was the belief expressed in an interesting discussion on "State Medicine," held at the Candlelight Club meeting recently at the Athearn Hotel, Oshkosh.

Dr. John M. Conley of Oshkosh and Dr. Gustave Windesheim of Kenosha were the principal speakers, but in the open forum that followed a large number of other physicians, as well as laymen, took part in the discussion. Neither Dr. Conley nor Dr. Windesheim advocated a system of state medicine, but both intimated that the tendency is in that direction. The speakers devoted their addresses to an explanation of the trend rather than to a discussion of the merits or demerits of the plan.

Dr. Conley supplemented his talk by reading portions of an address recently delivered on the subject by Prof. Glenn Frank, president of the University of Wisconsin. Dr. Windesheim illustrated his talk with an interesting chart showing the percentage of increase and decrease of certain specified diseases in the state. It was interestingly revealed by this chart that diseases which have

received particular attention from the state, have decreased.

A physician-surgeon service bureau, to handle all telephone calls for physicians, has been established at Racine. All residents of the city and county may telephone for their own physicians at the bureau and the call will be sent to them at once, or if the physician called for is not available, the bureau will obtain the services of another doctor.

It is believed that this service will greatly assist in case of accidents or other emergencies, as the bureau will be kept informed at all times of the whereabouts of virtually every physician in the city.

The bureau will also maintain a collection bureau for physicians and surgeons and has a complete list of trained and practical nurses on file so that they may be called at a moment's notice.

Dr. Alf Gunderson, La Crosse, gave an address on "Urology" before the Seventh District Nurses' Association at its December meeting at the Lutheran Hospital Nurses' Home.

Dr. W. A. Deerhake, superintendent of the Central State Hospital at Waupun, has returned from an inspection trip in the East. He visited New York City, Philadelphia and other cities where there are similar institutions.

"To promote and improve the quality and quantity of milk production and consumption, and do all things necessary and incident to the transaction of the business of the association" is given as the purpose of the Medical Milk Commission, Janesville, whose articles of incorporation were filed with the register of deeds recently. The official name of the organization, started a few months ago by a group of physicians, veterinarians and farmers producing raw milk for sale, is the "Rock County Medical Milk Commission Cooperative."

In its articles of cooperation, a board composed of fifteen directors will be the governing body. Incorporators are: Dr. Wayne A. Munn, Janesville; Dr. George W. Belting, Orfordville; R. A. Rougan, Beloit; Leigh J. Woodworth, Janesville; and Dr. Fred B. Welch, Janesville.

"It costs $7,238, conservatively estimated, to raise a child to the age of 18 years, an age when he is supposed to become self-supporting." Dr. A. M. Carr, Madison Health Commissioner, told members of the Knights of Columbus luncheon club recently. "The future earning of a man at eighteen is estimated at $41,000 with expenditures at $13,000 to $29,000. The peak of the earning power is reached at the age of twenty-five years. The economic value of a child at birth is $9,333."

Dr. Carl Neupert, who has recently established a practice in Janesville, read a paper on "Infant Feeding" at the monthly meeting of the Mercy Hospital Staff on Thursday, December 2nd. A 6:30 dinner was served to twenty-four physicians. Dr. M. A. Cunningham is president of the staff.

Dr. M. S. Corlett of Blanchardville, recently appointed deputy state health officer for the northern district of Wisconsin, was one of the chief speakers at the organization of the Marinette County Parent-Teachers Association.

The fight being waged in Wisconsin against the "white plague" was described by Dr. H. E. Dearholt, executive secretary of the Wisconsin Anti-Tuberculosis Association, at a recent weekly luncheon of the Rotary Club of Racine.

Dr. James Vedder of the Marshfield Clinic, who returned recently from a sojourn in Europe, brought back a product manufactured in Germany which is known as Lobelin Ingelheim. The preparation is used to counteract the effects of carbon monoxide. Lobelin Ingelheim is a liquid preparation which reacts almost instantly when administered to a monoxide gas victim while there is still heart action. In order to react effectively the antidote must be injected into one of the veins and for this purpose the preparation is contained in little needle-like tubes.

Dr. A. J. McCarey was elected president of the Green Bay Kiwanis Club at the annual election of officers held recently at the Hotel Northland. He will take the chair about the middle of January.

Dr. Xavier Corso and family, formerly of Cedar Rapids, Iowa, are now residents of Beaver Dam. Dr. Corso, who specializes in the treatment of the eye, ear, nose and throat, is a graduate of the University of Iowa and spent three years at the Wesley Memorial Hospital at Chicago before establishing his practice at Cedar Rapids.

"Better obstetrics mean better mothers and better babies," said Dr. Gustav A. Hipke in his talk before the Mothercraft class of the Maternity Hospital and Dispensary Association. "Prospective mothers should choose their medical adviser from the list of physicians who are willing to give up their time and knowledge because of their consecration to that work."

Dr. J. C. Kimberlin, formerly of Kansas City, Mo., has become associated with The Clinic at Ashland to take the place left vacant by the recent resignation of Dr. J. H. Gregory. Dr. Kimberlin specializes in the treatment of the eye, ear, nose and throat.

Dr. John R. Hughes, former president of the staff of St. Joseph's Hospital, Dodgeville, has been appointed dean of the College of Hospital Administration at Marquette University. Dr. Hughes is a former Marquette student and is a graduate of Rush Medical College, Chicago.

Outlining briefly medical progress, particularly in the

elimination and prevention of disease in the last two decades, and stressing especially the importance of care on the part of the individual to see that any symptoms of ill health are discovered promptly, Dr. S. E. Gavin addressed the members of the Fond du Lac Lions Club at one of their recent meetings.

At the third annual meeting of the North Central Branch, American Urological Association, Dr. H. M. Stang of Eau Claire was elected secretary-treasurer for the year 1927. The meeting was held at Cincinnati, Ohio, and Dr. Stang presented a paper on "Primary Tumor of the Ureter; Report of Three Cases."

The Newsboys of Yesterday entertained Dr. Joseph J. Eisenberg, former Milwaukee newsboy, at a banquet recently at the Elks' Club. Dr. Eisenberg returned from Vienna but a short time ago where he spent considerable time in post-graduate study.

Dr. T. M. Slemmons, who for the past two years has been connected with the Mendota State Hospital, has now established his practice at Monticello.

Dr. F. G. Tindall and family of Belleville will reside in New York City for the winter months, during which time the doctor will pursue a post-graduate course at one of the hospitals.

Dr. William L. Finnegan, Madison, was severely injured several weeks ago when a Milwaukee road train crashed into his car. He has been reported out of danger and there is continued improvement in his condition.

Dr. Carroll Rice, formerly of Lake Geneva, has opened an office at Delavan. He is the son of Dr. F. A. Rice of that city and is well known there, it being the home of his boyhood.

Dr. Gentz Perry, Kenosha, has been appointed as a member of the junior attending staff of the Marquette University hospital and as a member of the laboratory department in the service of roentgenology.

The following physicians were added to the staff of the dispensary: Dr. Fred W. Madison, department of medicine; Dr. Harold Nebel, department of surgery; Dr. Maurice J. Reuter, department of pediatrics; Dr. E. B. O'Leary, department of surgery; Dr. Sidney J. Silbar, department of surgery, and Dr. William J. Carson, department of surgery.

ENGAGEMENTS

Dr. John P. Koehler, health commissioner of Milwaukee, to Miss Edith R. Hulst, also of that city.

DEATHS

Dr. George A. Pugh, Kenosha, died on November 23rd following a heart attack which occurred while he was on his way to the home of a patient. Dr. Pugh was born in Milverton, Canada, March 8, 1873. He was an alumnus of Toronto University and of Rush Medical College, Chicago, from which school he was graduated in the year 1899. He was licensed in the state of Wisconsin immediately following his graduation and in 1900 established his practice in Kenosha.

Dr. Pugh was a member of the Kenosha County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. Surviving him are his mother, his wife and one son.

Dr. Leonard E. Spencer, Wausau, died at his home Saturday afternoon, December 4th. Dr. Spencer had been in ill health for about a year, suffering from a complication of diseases and during the last five weeks was confined to his home. The doctor came to Wausau from Maine, where he was born, forty-seven years ago when he was a boy of fourteen. He attended the Wausau High school and later, in 1897, graduated from the Jefferson Medical College of Philadelphia. For many years the deceased was deputy state health officer for the third Wisconsin district until his resignation a year ago.

Dr. Spencer was formerly a member of the Marathon County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his wife and one son.

Dr. Albert E. Halstead, Chicago, known to many Milwaukee physicians, died yesterday at St. Luke's hospital, Chicago, of valvular heart disease. Dr. Halstead was born in the year 1868 and was graduated from the Northwestern University Medical School in 1890. He was for many years chief of staff at St. Luke's hospital and was recognized as an eminent surgeon. Dr. Halstead is survived by his wife and two daughters.

Dr. E. E. Moore, resident physician of Merrillan since 1878, died at his home in that village on November 30th. Dr. Moore was born in 1855 and was a graduate of the Northwestern University Medical School in 1878.

Dr. Harry B. Sears, Oshkosh, died suddenly on Tuesday afternoon, December 14th. Dr. Sears had been deputy state health officer for the Third District for the past two years and formerly lived at Madison. For thirty years prior to coming to Madison in 1921, Dr. Sears practiced medicine at Beaver Dam. He was graduated from Rush Medical College in 1882 and received his Wisconsin license in the year 1900.

Dr. Sears was a member of the Dodge County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He is survived by his wife and four children.

Dr. John H. Baker, Bryant, died suddenly at seven o'clock Tuesday evening, December 14th, at his home. Death was caused by apoplexy. Dr. Baker was born at Campton, Ky., December 22, 1854, and was graduated from the Kentucky School of Medicine at Louisville in 1889. The doctor pursued post graduate courses at the same school in 1913 and 1918.

Dr. Baker was formerly a member of the Langlade County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his wife and five sons.

CORRESPONDENCE

Tax Deduction Allowed

TREASURY DEPARTMENT
INTERNAL REVENUE SERVICE

Milwaukee, Wis.
December 15, 1926

Mr. George Crownhart,
Secretary, State Medical Society of Wisconsin,
153 Oneida Street,
Milwaukee, Wisconsin.
Dear Sir:

Reference is made to your letter of the 23rd ultimo, wherein you inquire as to whether the cost of malpractice insurance, non-operative under any criminal charges, was properly deducted on the return of physicians as a business expense.

Your inquiry was submitted to the Commissioner of Internal Revenue for a ruling and I am today in receipt of his decision, which provides as follows:

"In S. M. 4078 (Cumulative Bulletin V-2) it was held that legal expenses incurred by a physician in the defense of a suit for malpractice in his profession represent allowable deductions on the ground that the expenses in question are so directly connected with the taxpayer's business as to warrant treating the expenses as ordinary and necessary business expenses. It is considered that the same principle is applicable in regard to premiums paid for malpractice insurance and that such premiums are deductible by physicians as ordinary and necessary business expenses."

Respectfully,
A. H. Wilkinson,
Collector.

Special Lectures

THE UNIVERSITY OF WISCONSIN
Madison

December 14, 1926.

Mr. J. G. Crownhart,
Editor, Wisconsin Medical Journal,
153 Oneida Street,
Milwaukee, Wisconsin.
Dear Mr. Crownhart:

You are to be greatly congratulated for the Reference Supplement to the December, 1926, issue of the Journal. May I respectfully request a copy of this Reference Supplement for my files? It is very handy in connection with the lectures in Pharmacology on alcohol and narcotics to list the essential points of the law in connection with their prescription. I would greatly appreciate having this for ready reference.

In your report before the 1926 House of Delegates, you suggest as a fourth recommendation that a special committee be appointed to discuss the subject of medical ethics, together with state laws regarding the practice of medicine, with the Deans of the two Medical Schools of the state, and to offer the services of the Society in providing each school with at least three lectures on such subjects to be delivered to senior medical students.

In this connection, I should like to call your attention to the fact that such lectures have been offered at the University of Wisconsin for the past two years. I have been giving a course on the History of Medicine on Wednesday afternoons in the second semester, which is open to anyone, and which includes a general discussion of medical ethics and the regulation of the practice of medicine by law. This year I am giving a series of five minute talks before the regular meetings of the University Medical Society on the development of medical ethics. I am very glad that you took occasion to point out the importance of such an effort as this.

With best wishes for a merry Christmas and a very happy and prosperous New Year, I remain

Faithfully yours,
Chauncey D. Leake.

Reference Supplement

MINNESOTA STATE MEDICAL ASSOCIATION
11 West Summit Avenue
Saint Paul, Minnesota

December 15th, 1926.

Mr. Geo. Crownhart, Secretary,
The State Medical Society of Wisconsin,
153 Oneida Street, Milwaukee, Wisconsin.
Dear Mr. Crownhart:

Congratulations on your December Medical Journal.

You certainly have given the members of your Society complete and valuable information.

Could you let me have about five extra copies of the Reference Supplement?

Thanking you very kindly in anticipation of the courtesy, and with the Season's Greetings, I am

Sincerely yours,
E. A. Meyerding,
Secretary.

EAM:JB

Of Value

THE UNIVERSITY OF WISCONSIN
STATE OF WISCONSIN GENERAL HOSPITAL
Madison, December 13, 1926.

Mr. J. G. Crownhart,
153 Oneida Street,
Milwaukee, Wisconsin.
Dear George:

Let me tell you that your supplement to your December number is a wonder. I can assure you that personally, it will be of infinite value to me.

Sincerely,
R. C. Buerki, M.D.

RCB:MEB

Valuable

RIVER PINES SANATORIUM
For Tuberculosis
Stevens Point, Wisconsin

Dec. 21, 1926.

J. G. Crownhart,
Secy. & Managing Editor,
Wisconsin Medical Journal,
Milwaukee, Wisconsin.
My dear George:—

I want to compliment you for the reference supplement to the Wisconsin Medical Journal received a day or two ago. I consider this one of the most valuable

documents issued by the Journal in a long time and it cannot help but be of very great assistance to the medical profession of the state.

Wishing you a Merry Christmas and a Happy New Year, I am

Very cordially yours,
J. W. Coon,
Medical Director.

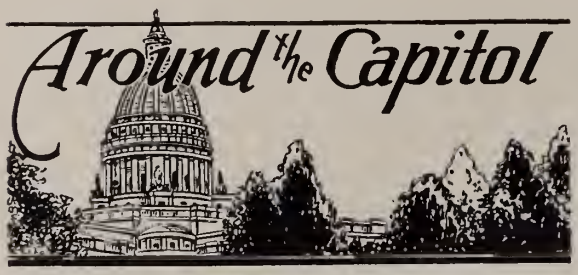
"MOST USEFUL"

Milwaukee, Wis.
December 27, 1926.

Mr. George Crownhart,
153 Oneida St.,
City.
Dear George:

No doubt the Journal Supplement idea—like many others emanating from that office—is yours. Accept my congratulations and thanks. It certainly is most useful.

Sincerely yours,
FHH:GC F. Herbert Haessler.



Work has already been started excavating for the Service Memorial Institute at the University of Wisconsin and contracts have been let for the construction of this new building at a cost of approximately $600,000. The new building is to be ready for occupancy by September, 1928. Dr. Charles R. Bardeen, dean of the Medical School at the University of Wisconsin, declares that this is the first separate medical building to be erected, although medical instruction was authorized by the University as far back as 1855.

* * *

With the divorce rate advancing in Wisconsin and the marriage rate declining, the State Board of Health announced today that Wisconsin data, just compiled, showed women obtained two-thirds of the divorces the past year.

The number of divorces for 1,000 marriages in Wisconsin increased from 147 in 1924 to 153 in 1925 according to statistics compiled by the State Board of Health of Wisconsin. The number of divorces per 1,000 population increased from .81 per cent in 1924 to .84 per cent in 1925. The number of marriages per 1,000 population decreased from 5.67 per cent in 1924 to 5.66 per cent in 1925.

In commenting on the increase of 5.3 per cent of divorces in Wisconsin for 1925 as compared with 1924, L. W. Hutchcroft of the State Board of Health of Wisconsin declared:

"It is practically impossible to trace the cause of the increase of divorce in Wisconsin, for the cause of divorce itself is intangible. Divorce is an evil at the root of our social structure and is a result of the era of moral wane which our country has undergone since the World War. Some people attempt to assign the increase of divorce to the enfranchisement of women, for women are realizing their rights and independence and are refusing to submit to their husbands as their lords and masters. The increase of the divorce evil, just like the falling off of church attendance, is a characteristic of this age, which, if it cannot be called immoral is at least unmoral."

* * *

More fur farms have been started in Wisconsin this year than in the three previous years, according to the records of the state conservation commission which show a total of 360 fur farms started since 1923, counting only those for which a state license is required, of which 200 were launched during 1926.

Besides these farms there have been scores of fox farms which the state does not license and as a result has no data on their numbers. The state licenses farms for the propagation of muskrat, mink, skunk, raccoon, beaver, otter and fisher.

Muskrat farms, with about 110 licensed, are the most common fur animal reserves in the state. Licenses for skunk, mink and raccoon farms are about evenly distributed, while there are very few permits issued for beaver or otter raising. Muskrat reserves are most common in the Fox River valley region near Oshkosh, Winneconne, and Butte des Morts, where the great amount of water makes the section favorable to the raising of muskrat.

* * *

A state bank chartered in a Wisconsin town, village or city cannot move to another community, Attorney General Herman L. Ekern held in an opinion to the state banking commission. A charter of a state bank cannot be amended so that the location of the bank can be changed from one municipality to another.

* * *

The final settlement of all phases of the Wisconsin-Michigan boundary dispute leaves Wisconsin in undisputed possession of land assessed at more than $16,000,000 that was involved in the dispute and is an entire victory for the Badger state, Attorney General Herman L. Ekern declared in a statement.

"The territory in the Michigan-Wisconsin boundary controversy included a strip of land about 235,000 acres in area extending from a point about eight miles east of Hurley to Lake Brule in Forest county, also about 120 islands in the Menominee river ranging in area from less than an acre to over 300 acres, some of them being covered with second growth timber, and some very highly developed," Mr. Ekern declared.

"The decree entered sustains the position taken by Wisconsin and awards to Wisconsin all the territory which she has claimed and has possessed. Michigan does not get any territory that was ever possessed by Wisconsin. Two so-called islands, Merryman, near White Rapids in the Menominee river, and Sugar island, have always been taxed by Michigan and considered to

be a part of the Michigan mainland and the court's decree so finds."

* * *

Before retiring from the executive office, Governor John J. Blaine announced a number of appointments. Among them were:

Board of Examiners in Basic Sciences: Prof. William D. Burdick, graduate of the University of Wisconsin, Professor of Chemistry in Milton College, trained in biology and medical chemistry; to succeed Prof. F. G. Hall, resigned, for unexpired term ending April 1, 1927.

Board of Pharmacy: B. J. Kremer, Fond du Lac, to succeed himself, for term ending April 12, 1931.

* * *

Death of parents is not the major cause for the breakdown of Wisconsin homes which results in placing children in the Wisconsin state public school, according to a study made by Miss Kathryn Goodwin, Madison, under the direction of Prof. J. L. Gillin of the university.

A study of the 825 children in the state public school showed that in only 19 cases both parents were dead and that in 159 cases one of the parents was dead. In most of these cases the death of parents was not the direct cause of commitment to the school.

The investigation showed that improper guardianship —cruelty, neglect, sex delinquency, intemperance, or criminality of parents or guardians—was the direct cause of most commitments, 24.9 per cent of the total. The next most frequent cause was desertion which caused 24.8 per cent of the commitments. Then came illegitimate births, 15.8 per cent; death, 10.2 per cent; mental defect or disease of parents, 10.1 per cent; special needs of the child, 5.9 per cent; and a small number of commitments caused by physical disability of parents, poverty, separation or divorce.

* * *

Although the state has no provisions for the removal of snow from its highways, counties in cooperation with local communities kept 1,400 miles of state trunk highways open last winter and are duplicating this work this year, according to the state highway commission.

The cost of this snow removal program amounted last year to $56,600, an average of about $40.50 a mile. Besides these highways about 1,000 miles of county trunks were kept open last year at a cost of $25 a mile. A total of 113 units of snow removing equipment was used in the state last year.

With Wisconsin's expensive network of highways it is thought probable that an effort will be made at the coming session of the legislature to work out a definite program of snow removal to co-ordinate the present sporadic efforts at snow removal.

* * *

The county board has power to abolish the county's municipal court, the attorney general's department ruled in an opinion to District Attorney L. L. Bruemmer, Forest county. When abolished such a court would cease to exist at any time fixed by the board, irrespective of the term of the municipal judge. The municipal judge does not continue to hold the power of the court commissioner after the abolition of the court.

* * *

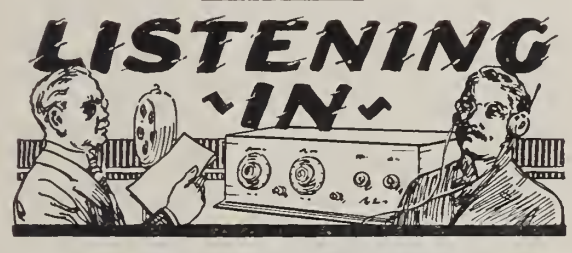
The Wisconsin marriage laws should be strengthened to bring about more efficiency in barring the unfit from wedlock, according to Prof. John L. Gillin of the sociology department of the University of Wisconsin.

"The Wisconsin eugenic law is but the first step in the direction toward controlling marriages," Prof. Gillin declared. "The law is too loosely constructed. In order to procure a marriage license it provides that a man must submit to a medical examination and receive a certificate that he is free from venereal disease. However, adequate examinations cannot be given at the fee of $3 which is established, and consequently the tests are not as effective as they might be."

* * *

In spite of their scarcity last spring, partridges have survived over the open season and are now reported being seen in large numbers in some counties. Game wardens report that few of the birds were shot this year with the appeal sent out by Elmer S. Hall, state conservation commissioner, to save the birds due to their diminishing numbers. The birds are said to have experienced a big hatch, many having nested late. Alarmed at the scarcity of the birds prior to the opening of the season, the conservation commission posted signs appealing to sportsmen to spare partridges in their hunting activities. The commission had no power to revoke the open season. It is believed that with the increase in the numbers of birds it will be possible to have an open season next year without placing the birds in danger of being wiped out.

* * *



SERVICE VALUABLE

Among the office callers during the Holidays was Dr. Phillip Corr of Juneau. Dr. Corr came in to commend the weekly press releases of the State Medical Society and declared that their use in the Juneau Independent each week constituted a valuable service to the public and profession alike.

MORE PAPERS LIKE IT

During December close to a hundred weekly and daily papers asked to be added to the Society lists to receive the weekly press releases on public health and scientific medicine. The total of the papers using this service is now close to the 275 mark.

HYGEIA APPRECIATED

Before Christmas the State Society again presented some 300 subscriptions to "Hygeia" to legislators, state officials, district attorneys, certain libraries, and to a limited number of prominent and interested laymen.

Letters of appreciation are now pouring across the Secretary's desk. It is apparent that this lay educational measure of the Society meets with favor.

CAN REVOKE LICENSE

A Milwaukee physician has served a term in the federal prison and paid a fine for conspiracy with others to commit offenses against the United States under the prohibition act. The Attorney General has ruled that such offense constitutes evidence of a crime involving "moral turpitude" and that the State Board of Medical Examiners "is empowered by our statute to revoke his license to practice medicine."

HELD LIABLE FOR ACCURACY

Upon suggestion of a member, the Secretary addressed the Prohibition Administrator for the Eastern District of Wisconsin, asking that they set forth their position on the question, "To what extent are physicians held liable for the accuracy of names and addresses of patients shown on their prescriptions?"

"It is not incorrect to say that physicians are held responsible for the accuracy of the names and addresses of patients as shown on their prescriptions," declared Mr. E. C. Yellowley in reply.

"Some physicians, since accuracy in this respect has been more insisted upon, have complained that patients gave them false names and addresses, and that they should not be held to the accuracy of the information so obtained. In reply thereto, it might be stated that no physician would cash a check or lend money to a person with so little inquiry as some physicians appear to give in the issuance of prescriptions. If a patient is found in good faith to require a whiskey prescription, he should not be offended if the physician informs him that he is held to accuracy in his reports, and, that he desires some means of identification of the patients, such as, letters, fraternity cards, etc. Nearly everyone has some means of identification about his person, and it is not unreasonable to require a physician to exercise reasonable care in this respect.

"It is possible that even with the exercise of a reasonable degree of care, a physician might sometimes, when actual medical need existed, be fooled by the patient as to the correct name and address, but it is altogether unreasonable to expect that a physician should issue an entire book of prescriptions to entire strangers, all of whom gave him wrong names and addresses."

AT WASHINGTON

Diseases of the heart were the principal cause of death in 1925 according to an announcement December 27th. Nephritis was second, pneumonia was third, with cancer, all forms of tuberculosis and cerebral hemorrhage following in the order named.

The Circuit Court of Appeals has upheld a lower federal court decision that the sale of paregoric by a pharmacist without a prescription constitutes a violation of the Harrison Narcotic Act.

Senator Hawes (Dem., Mo.) has introduced a bill (Senate Bill No. 4915) to remove restrictions upon intoxicating liquors for medicinal use.

"The present law," declared Senator Hawes, "sets the physician apart * * * and tells him by law what he shall or shall not do in the practice of his profession. The American theory of law is reversed and the physician is subjected to the abhorrent doctrine of being constantly suspected of being a criminal because he exercises his individual professional judgment in the administration of certain medicines."

Miss Grace Abbott, chief of the Children's Bureau, in a report issued Dec. 13th recommends the continuation for two years of the appropriation for administration of the Sheppard-Towner Act now pending in the Senate. She explains that the present appropriation expires June 30, 1927 and urged speedy legislation that corresponding legislation might be obtained in the state legislatures this winter. Miss Abbott declared that the original five years was much too short a time to carry out a public health program and that "to discontinue now will be to fail to secure the proportionately greater results that will follow this period of preliminary organization."

The 1921 death rate was 68 per 10,000 live births. In 1925 the rate was 65.

Drug addicts in the United States are decreasing in number according to L. G. Nutt, chief of the narcotic division. Mr. Nutt estimated that there were less than 100,000 at the present time.

Veterans' Bureau hospitals have treated more than 500,000 since September, 1919, according to official report. Total beds available in such hospitals classified as to use follow: Tuberculosis, 7,313; Neuropsychiatric, 8,051; and general medical and surgical, 5,234.

"Of the total patients remaining under treatment on June 30, 1926, 5,012 or 20 per cent were receiving hospitalization for non-service connected disabilities," declared the report. "This hospitalization is indicative of the relief that was made possible by Congress in extending hospital care to the veterans of all wars, military occupations, and military expeditions, without regard to the origin of their disabilities."

The right of Congress to limit the use of liquor for medicinal purposes to one pint every ten days was upheld by the U. S. Supreme Court by a five to four decision. The opinion was written by Justice Brandeis and concurred in by Chief Justice Taft and Justices Holmes, Van De Vanter and Sanford. The dissenting opinion was written by Justice Sutherland and concurred in by Justices McReynolds, Butler and Stone.

"If Congress," said the majority opinion, "may prohibit the manufacture and sale of intoxicating lzzz malt liquor for medicinal purposes by way of enforcing the Eighteenth Amendment, it equally and to the same end may restrict the prescription of other intoxicating liquor for medicinal purposes. In point of power there is no difference; if in point of expediency there is a difference, that is a matter in which Congress alone may consider."

TWENTY YEARS AGO

Milwaukee Medical College and Marquette College were united to form Marquette University.

The Journal commended the State Board of Medical Examiners for the arrest of Willis F. and Wallace A. Reinhardt who operated the "Wisconsin Medical Institute." Commenting on this case the Journal referred to the Reinhardts as the "heavenly twins."

An editorial page was devoted to censure of a member for an article (illustrated by the member's picture) given the press upon his return from Europe. It is interesting to note that during 1926 but one press item appeared in the state which was given censure by the Committee on Ethics.

As a relief from the flood of incompetent medical graduates the Journal suggested that admission to medical schools should be only through an officer appointed by and responsible to the State Board of Medical Examiners of the respective states.

SOCIETY RECORDS

NEW MEMBERS

Halbach, Robert McC., Howard Hosp., South Broad St., Philadelphia, Pa.

CHANGES IN ADDRESS

Margoles, F. C., 760 Lincoln Ave., Milwaukee, to Henke Clinic, La Crosse.

Huber, G. W., Minocqua, to Merritt, Fla.

Corlett, M. S., Blanchardville, to 214 Clark St., Rhinelander.

Purdy, F. P., Winneconne, to Mukwonago.

Rice, C. W., Milwaukee, to Delavan.

The Medical Referee

BY MR. ARTHUR B. DOE

Milwaukee

This address, presented before the Milwaukee Academy of Medicine on October 25, 1926, was reported expressly for the use of this Journal. An attorney of high repute, Mr. Doe has long been interested in the application of medical testimony. His address and the resulting discussion will be of interest to every member.—Editor's Note.

I read a short time ago in one of the medical journals a copy of the resolution introduced by Dr. Horace Manchester Brown on this subject at the American Medical Association meeting, in which he advocated the introduction into this country of the use of medical referees, primarily in criminal cases.

In considering this subject, the first aspect of it is, how far have we gone in that direction to date. In criminal law we have made next to no progress. In the personal injury cases, other than those governed by the Compensation Act, we have similarly made next to no progress. Under the Compensation Law as it is administered in Wisconsin, we practically have a system of the medical referee.

Everyone recognizes at once that in industrial cases there are many cases where no referee is necessary, either because the medical men on both sides of the issue enjoy the full confidence of the Commission, and the medical referee would be of no assistance, or in other cases because the question that comes up on the medical side is not such a question as lends itself to determination by a medical referee. But with those cases eliminated we now have in Wisconsin in industrial cases practically a system of the medical referee.

Now in England they have a different means of arriving at the same end. The English Workman's Compensation Act is administered by a county judge. A medical man sits on the Bench with the judge while the cases are tried. He, however, gives no testimony but simply decides the medical questions in the case and gives the judge his assistance in that way. He is known under the English practice as the medical referee.

To my mind our system that is in vogue in Wisconsin of having a medical referee, chosen by the Examiner or Commissioner who hears the case, in any case where it is deemed necessary or advisable, is a better system than the system that they have in England; for this reason: Their system of government, unlike ours, is able to keep a doctor who sits on the Bench with the county judge, out of politics, which is, of course, something we cannot do under our system of government.

It would be a mistake, according to my idea, to complicate the system of the law of personal injuries by adding another political figure in the person of a medical referee who would be elected by the people or appointed by the Commission to hold office, to sit with the Commission or the Examiners as they hear these cases around the state. It is very much better to have the Commission choose the particular man on the particular case whose views they want to adopt and be guided by.

So I think that we have accomplished here in Wisconsin a good deal along the lines of getting away from very one-sided medical testimony upon the one hand and very one-sided testimony on the other hand, which leaves the Judge or Examiner or Commissioner in hopeless confusion when the testimony is all in, because in such cases the practice is now developed that the Gordian knot can quite readily be cut by what we might describe as the medical referee.

Recently I was in Madison and talked to two members of the Commission there about the difficulties that they have in working out this system that we are now using in industrial cases. They called my attention particularly to several things which I am going to mention here, because very few of those present I take it, are what we lawyers are accustomed to refer to as industrial surgeons or people who are constantly before the Commission and familiar with the manner in which it works. I asked them, having this occasion in mind, what they thought about the medical situation as it appeared to the Commission at present, whether it was satisfactory, whether the system of referring a case to a referee was working well. They told me that their greatest difficulty was this: Certain men appear repeatedly before them; they get to know those men and to rely upon certain ones and not upon others. They spoke of several cases where an individual doctor (no names were mentioned of course) would appear on one case for the applicant and give a very extravagant estimate of the disability; and then in a week or two he would be before the Commission for a self-insurer or an insurance company and greatly depreciate the disability in that case. The comment was, of course, that a physician who got himself into that position not only entirely destroyed his own usefulness to either side, because the Commission was not in the habit of paying any attention whatever to what he said, but also he destroyed his usefulness not only to the Commission but to the medical profession and to himself professionally, because he never could be used as a medical referee. Instances were cited where the variation in estimates of disability were put by some men at 10 per cent and by others at 75 per cent. And the view was expressed that differences of opinion as marked as that could not be honest differences of opinion. In other words, when the applicant who offers his testimony first comes in with an extravagant estimate, it is not unusual for the respondent to make an equally extravagant estimate in the opposite direction, so that by the law of averages the split between them would come somewhere near the truth. That sort of testimony they greatly deplore.

The idea of the Commission as to the remedy for the situation is that the medical profession should regard their testimony, regardless of which side they are called by, as in the nature of a judicial opinion about the case; that is to say, that they are not partisan in the matter at all, but that they are there stating a scientific fact for the guidance and help of the men whose duty it is to decide the case, and that they will not give testimony to establish the correctness of the position of one side or the other.

Those of you who have appeared before the Commission repeatedly know that these things are in the minds of these Examiners and Commissioners. Those who go less frequently I think are the ones who have the greatest difficulty on that account. This has happened. Doctors go in with an extravagant statement of the disability, and then the award does not turn out that way, and the result is bitter criticism by the injured man and his family, of the Commission, which they resent. That works not only on percentages of loss of function, but it also works on the vital question of whether the disability in the first place is due to an injury. When an effort is made to establish a connection between a disability and an injury beyond a reasonable limit, and the Commission is compelled to decide against the injured man, the criticism goes back to the Commission, and naturally they feel when that happens that very frequently the criticism should be directed to the man who failed to act as a medical referee for them, and took a partisan position instead of a judicial one with the Board.

In the last two sessions of the legislature the Federation of Labor has in each session introduced a bill to abolish the panel provision of the law. I think it highly probable that the reason for the introduction of those bills has been these cases which the Commission has referred to. Injured people come away from a Commission hearing where they lose the case, convinced that the reason that they lost was that the physicians who took care of them were in the employ of the employer or of his insurance company, and that they did

not have an opportunity to have a man of their own choice take care of them and give his opinion; also that the Commission does not attach the weight to the testimony of physicians who come in late in the case for the applicant, that they do to those on the panel.

Now the Commission is thoroughly in favor of a retention of the present panel provision. They are quite aware that its repeal as contemplated by the bills introduced by the Federation of Labor would result in the employer having nothing whatever to say about the physician in charge of any injured man, and the consequence of that will be that these men will drift into the hands of chiropractors and faith healers, and all sorts of quacks, with very disastrous results.

I think the best way to establish a reaction to the tendency to do away with the panel provision of the law is for the medical men who go there, to avoid in every case that tendency toward extravagant statements, with the idea that the Commission will break in the middle, and that approximate justice will be done.

Now that is the state of affairs at the present time on the subject of medical referees. We are at the point where it is to a large extent in the hands of the medical profession to say whether in every case where there is a great difference of opinion a medical referee shall be called in, or whether the confidence of the administrative Board in the profession can be built up to such a point that this is unnecessary. I am firmly convinced that our system of having a medical referee only when necessary, is better than to follow the English system and add a man to the Commission to sit on every case.

The next aspect of the question which I want to consider with you briefly, is this, how much further can we go in that direction? When you go back into the early history of the Common Law you find that originally liability in accident cases was not predicated upon the basic idea of fault—negligence. That was a thing that came with the years. It probably arose out of the idea in every man's mind when injured, that the other man is to blame, and that from the fact that he is to blame necessarily follows the liability for damages. We are gradually getting away from that idea of fault. The history of the Common Law of negligence is the history of the growth of the idea of fault as the basis of liability, with various defenses coming up, such as the fellow servant doctrine, assumption of risk, contributory negligence, and so on. Then when the extreme was reached, the pendulum began to swing in the other direction, and the first step was the abolition of the defense of assumption of risk. Following that came the abolition of the idea of fault in all master and servant cases. Now there is no logical reason why the idea that fault is not an intelligent basis for liability should be limited to master and servant cases. The basic theory of the Workman's Compensation Act was the fundamentally sound idea that where there is an economic loss due to injury that loss should be borne, not by the injured man, but by the industry in which the loss occurred. That is the fundamental thing back of the Compensation Law. If a man having nine children is killed in a factory, through the Compensation Act you can distribute that loss over the industry, and the widow is going to be paid regardless of whether there was any element of fault present, or whether there was not. No inquiry is made as to who was at fault. Logically there isn't any difference in the economic laws if that same man is killed in an automobile accident. His widow is just as likely to get into the Poor House in one case as another, and his children are just as likely to become public charges in one case as another. The problem of the maintenance of the children and family is going to be the same whether the accident happened on the street or in a building. And this hobby of mine that I spoke of is to so elaborate the scope and powers of the Industrial Commission that it will include personal injuries of every kind, automobiles, railroads, street cars, elevators, buildings in general, people who fall downstairs in stores, and who slip and fall in public places, so that all questions which now depend for their solution on the determination of an answer to the question, who is at fault, will come on the same basis. The economic loss is the same as though they were killed in industry, and it will be borne by the body politic and not by the individual concern.

The first logical extension is to include automobile accidents under the Compensation Law. Now this idea is not original with me. I am not sure that it was original with the Ohio judge who first brought it before the public. But in the Journal of the American Bar Association an article appeared on this subject about two years

ago, in which it was advocated that the system of trying automobile cases before juries should be abolished, and that the losses because of traffic accidents should be spread over all those people who use automobiles, just as industrial accidents now involve the distribution of the losses over the industry in which the accident occurs. I have been considering this subject ever since I read that paper. I have been working on it with Mr. George Williams of Oshkosh, who is very much interested in the same idea, and who did considerable work on it at the meeting of the American Bar Association this summer. The idea has the approval of the great body of the Bar who have been approached on the subject. It has the approval of a number of the largest insurance companies. The importance of that is that the insurance companies generally are opposed to compulsory insurance of automobiles. They believe that the hazards of automobile accidents would be increased by compulsory insurance, that conditions would be worse than they are now instead of better if you stop with compulsory insurance and base the determination of the liability on the question of fault that is involved in every jury case.

The extension of the principle of Workmen's Compensation to automobile accidents is full of difficulties. At the outset you meet the difficulty of the man who comes from outside of the state into Wisconsin and injures someone. You meet difficulties on the subject of cost. This is to say, if you have a law that requires everyone who is injured by an automobile to be paid, the financial responsibility of the man who has to pay is of course a primary consideration. I believe the direction in which we have to work is this: Those difficulties were just as great when the Compensation Act was first considered. There were nonresident employers, there were irresponsible employers, and there were various other difficulties that apply equally to both kinds of cases. None of them has prevented the Compensation Act from being an unqualified success. If you gentlemen were to go about amongst a group of employers, or the Association of Commerce, and ask how many of them would like to see the Compensation Act repealed, you would find practically none opposed to the Act in its present form. There are only nominal exceptions to the universal application of that law. Practically every employer in the state of Wisconsin is subject to the Compensation Act, and practically every employer would oppose its repeal. That is also true among laboring men. The Federation of Labor is an enthusiastic supporter of the Compensation Act and of the Industrial Commission. The working man does not want to go back to the old system where he had to meet the defenses of assumption of risk, fellow servant, and contributory negligence, and where he had first of all to make out a case of negligence of the employer before he even got to the second hurdle of the defense.

Now if the Compensation Law has given practically universal satisfaction, and that is really the situation, we are at the point where there is no reason to believe that the obstacles in the way of extending it to all kinds of injuries, and the abolition of the whole idea of fault as the basis of liability should not meet with equally enthusiastic approval. The difficulties which confronted the framers of the Compensation Act were just as great as those which confront those who are trying to frame an act such as I am discussing.

Now I want to mention the unsatisfactory character of jury trials as a method of arriving at justice. It has become almost a byword that juries try lawsuits on everything except the evidence. One of the great jury lawyers of Wisconsin told me one day that he lost a case in Oshkosh because at the end of his argument he did not thank the jury for the attention that they had given to the trial. He found out afterwards that in the jury room the jury discussed that proposition to the exclusion of everything else, and that they absolutely refused to bring in a verdict in favor of a lawyer who had not thanked them for the attention they had given to the case.

I could multiply illustrations, and I know you have all heard many of them and realize that if one of the parties has red hair it is as important to the jury as most of the evidence in the case. Many juries are composed of perfectly honest and intelligent people, but many are not, and our system of choosing a jury is not all that it might be. There is a widespread opinion among people that juries are very unsatisfactory things, and I daresay that those of you who have testified in jury trials have not been impressed with the idea that the trial was conducted in a manner calculated to arrive at a just result. It is in the nature of a show. The side that puts on the best show generally wins the case. Night before last I read a

definition of a jury. It said that a jury was a body of men who were selected to determine which side had the best lawyer. And that is not the least of the evils of the method of administering these cases.

The application that this has to this occasion is not only that we do away with the jury trial. That is merely incidental. I do not say that the jury is not right more often than wrong. I think probably juries are right more often than they are wrong. But they are not right nearly as often as the Industrial Commission is, by a good deal. And why? Because the jury now has to go through what we call a special verdict. Frequently this verdict is as long as 16 questions. They kind of steer down between Scylla and Charybdis to reach a verdict which will arrive at the result they want to reach. Frequently they are astonished when they find they have not reached it after the judge has rendered judgment on the verdict. The difficulties that they have to contend with are enormous, and the difficulties that the court has to contend with are enormous because the thing is protracted and dragged out for days on end. Few jury cases are finished in half a day; not many are finished in one day. It is not uncommon for an ordinary personal injury action to last a week. The case that lasts a day before the Industrial Commission is exceedingly rare, probably not one in a year's time. And why? Because all questions except whether or not the man was injured in the scope of employment, and the extent of his injury, are eliminated. Everything else is out of the case, and you have to address yourselves to only those two propositions. Now a jury draws $4 a day per man. We have now in Milwaukee County some 8 branches of the Circuit Court. Each one of those branches with the single exception of the calendar judge, frequently has a jury. There are juries in 7 courts, each one with 12 people drawing $4 a day. In addition there are six branches of the Civil Court, and they have juries almost every day. There are two criminal courts, and one of them has a jury practically every day, and the other very commonly. The cost is enormous. The cost of administration, quite apart from juries, is enormous. The trials go so slowly that we have twice as many judges as would be needed if the personal injury business was out of the courts. All of the witnesses who testify on these questions of fault are being paid to be in court. And that is not the biggest part of their loss. They all lose a day's wages if they are working men, and in any event lose a day's time and probably more, possibly a week. All of that would be eliminated, and the economic saving would be enormous.

The number of industrial accidents at the time the Industrial Commission was created was probably as great as the number of automobile accidents of to-day. If we did not have the compensation law the chances are that the number of master and servant cases would equal in number the automobile cases of to-day.

So that whereas we have this enormous machine to administer this law of fault in the court houses all over the state, the Industrial Commission, with 3 members and 3 examiners, does the entire business for the state on master and servant injuries. With twice the number they could do both and then they would not have as many men hearing cases as we have judges in Milwaukee County by at least a third. So you can see the idea has possibilities. Now all of this is probably of more interest to you as individuals in the community than it is as doctors. But the point that I wanted to bring home particularly to you about it is this: I think you are probably all in favor of the proposition that I spoke of, that the time has come when the system under which criminal cases are tried, and I mean now as respects pleas of insanity and things of that nature, is a relic of barbarism. We have progressed far beyond that. There is nothing as conservative in our modern civilization as the law. There is nothing as antiquated as the law and the method in which we administer it. If the step that Wisconsin took in 1911, when the Compensation Act was passed, has given practically universal satisfaction, there is no reason to believe that this proposal would give less satisfaction. The hurdles are not insuperable.

What that means to you as doctors is that all these automobile cases—and when I say automobile cases I really mean personal injury cases of every kind where there now is any question of fault involved, would come before this Board, and the medical questions would be determined as they now are, before this Board, where there was an honest difference of opinion between medical men, by a medical referee. We have already gone part of the way, and it is not going to be impossible to

(Continued on Page XXII.)

THE JOURNAL BOOK SHELF

Defective Memory, Absentmindedness and Their Treatment. By Arnold Lorand, M.D., Carlsbad, Czecho-Slovakia. F. A. Davis Company, Philadelphia, 1926.

The Treatment of Fractures. With notes upon a few common dislocations. By Charles Locke Scudder, M.D., consulting surgeon to the Massachusetts General Hospital. Tenth edition, revised. Octavo volume of 1240 pages, with 2027 illustrations. Polished buckram, $12.00 net. W. B. Saunders Company, Philadelphia and London, 1926.

Practical Dietetics for Adults and Children in Health and Disease. By Sandford Blum, M.D., Head of Department of Pediatrics, and Director of the Research Laboratory, San Francisco Polyclinic and Post Graduate School. Second revised edition; price $4.00 net. F. A. Davis Company, Philadelphia, 1926.

Physiotherapeutic Lectures. Third edition. Condensed report of lectures, clinics and discussions at Fourth Annual Physiotherapeutic Convention. H. G. Fischer & Co., Inc., 1925.

Diathermy with Special Reference to Pneumonia. By Harry Eaton Stewart, M.D. Second edition, revised, with 45 illustrations and 15 charts. Paul B. Hoeber, Inc., New York, 1926.

The Ophthalmic Year Book. Volume XXII. Containing bibliographies, digests and indexes of the literature of ophthalmology for the year 1925. Edited by William H. Crisp. Published by the Ophthalmic Publishing Company, Chicago, September, 1926.

Medical Clinics of North America. Philadelphia number, September, 1926. Volume X, Number 11. Octavo of 217 pages with 16 illustrations. Per clinic year, July, 1926, to May, 1927. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

Acute Epidemic Encephalitis. (Lethargic Encephalitis) An investigation by the Association for Research in Nervous and Mental Diseases. Report of the papers and discussions at the meeting of the association; New York City, December 28th and 29th, 1920. Paul B. Hoeber, New York City.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared original articles on treatment, medicine, surgery, neurology, pediatrics, obstetrics, gynecology, orthopedics, pathology, dermatology, ophthalmology, otology, rhinology, laryngology, hygiene, and other topics of interest to students and practitioners. Volume III. Thirty-sixth series, 1926. J. B. Lippincott Company, Philadelphia and London.

The Duodenal Tube and Its Possibilities. By Max Einhorn, M.D., Prof. of Medicine at the New York Post-graduate Medical School; visiting physician to the Lenox Hill Hospital, New York. Second edition, revised and enlarged; illustrated, F. A. Davis Company, Philadelphia, 1926.

Essays in the History of Medicine. By Karl Sudhoff, M.D., translated by various hands and edited by Fielding H. Garrison, M.D., Lieutenant Colonel, Medical Corps, U. S. Army. Volume II of The Library of Medical History; $5.00 postpaid. Medical Life Press, New York, 1926.

Pathology of the Nervous System. By E. Farquhar Buzzard, M.D., physician to St. Thomas' Hospital and physician to outpatients at the National Hospital for the Paralyzed and Epileptic, and J. Godwin Greenfield, M.D., pathologist to the National Hospital for the Paralyzed and Epileptic. Paul B. Hoeber, New York City, 1925.

Modern Clinical Syphilology. By John H. Stokes, M.D., Prof. of Dermatology and Syphilology in the School of Medicine, University of Pennsylvania. Octavo of 1444 pages with 885 illustrations and text figures and more than 200 detailed case histories. Cloth, $12.00 net. W. B. Saunders Company, Philadelphia and London, 1926.

BOOKS RECEIVED FOR REVIEW

Hygieia, or Disease and Evolution. By Burton Peter Thom, M.D. E. P. Dutton & Company, New York City.

Index of the Collected Papers of The Mayo Clinic and The Mayo Foundation, 1884 to 1925. W. B. Saunders Company, Philadelphia and London, 1926.

Report on Third International Congress of Military Medicine and Pharmacy. Paris, April, 1925. By Commander William Seaman Bainbridge, M.D., United States Naval Reserve Forces, Member of Permanent Committee, Delegate from the United States. Reprinted from The Military Surgeon, May to August, 1926, inclusive, Washington, D. C.

Principles and Practice of Chemotherapy with special reference to the specific and general treatment of syphilis. By John A. Kolmer, M.D., Prof. of Pathology and Bacteriology in the Graduate School of Medicine, University of Pennsylvania. Pages, 1106, with 82 illustrations; price, cloth $12.00, net. W. B. Saunders Company, Philadelphia and London.

Surgical Clinics of North America. Vol. VI, No. 4, Mayo Clinic Number, October, 1926. Pages, 274, with 91 illustrations. Paper, $12.00; cloth, $16.00, net. W. B. Saunders Company, Philadelphia and London.

Human Pathology. A Textbook by Howard T. Karsner, M.D., Prof. of Pathology, School of Medicine, Western Reserve University, Cleveland, Ohio. With an introduction by Simon Flexner, M.D. Illustrations, 20 and 443, black and white. J. B. Lippincott Company, Philadelphia and London.

Readings in Abnormal Psychology and Mental Hygiene. Edited by W. S. Taylor, Prof. of Psychology in Smith College, with an introduction by Joseph Jastrow, Prof. of Psychology in the University of Wisconsin. D. Appleton and Company, New York and London, 1926.

Medical Clinics of North America. Vol. X, No. 3, Mayo Clinic Number, November, 1926. Octavo of 275 pages with 55 illustrations. Per clinic year, July, 1926, to May, 1927. Paper, $12.00; cloth, $16.00, net. W. B. Saunders Company, Philadelphia and London.

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History of the Mayo Clinic. Octavo volume of 185 pages, illustrated. Cloth, $3.50 net. W. B. Saunders Company, Philadelphia and London.

The Practice of Medicine. By A. A. Stevens, M.D., Prof. of Applied Therapeutics in the University of Pennsylvania. Second edition, entirely reset. Octavo of 1174 pages. Cloth, $7.50 net. W. B. Saunders Company, Philadelphia and London.

Practical Surgery of the Joseph Price Hospital. By James William Kennedy, M.D., Surgeon to the Joseph Price Hospital, Philadelphia; Consulting Surgeon to the Norristown, Coatesville and Chambersburg Hospitals; formerly in charge of the Gynecological and Obstetrical Department of the Philadelphia Dispensary. Illustrated with 129 original half-tone plates, some in colors. Price $10.00 net. F. A. Davis Company, Philadelphia, 1926.

Physiology and Biochemistry in Modern Medicine. By J. J. R. Macleod, M.D., Prof. of Physiology in the University of Toronto, Toronto, Canada; assisted by Roy G. Pearce, A. C. Redfield, N. B. Taylor, and J. M. D. Olmsted. Fifth edition, with 291 illustrations, including 9 plates in colors. Price $11.00. C. V. Mosby Company, St. Louis, 1926.

An Introduction to the Practice of Preventive Medicine. By J. G. Fitzgerald, M.D., Prof. of Hygiene and Preventive Medicine and Director, School of Hygiene and Connaught Laboratories, University of Toronto; assisted by Peter Gillespie, Prof. of Civil Engineering, University of Toronto, and H. M. Lancaster, Chief Dominion Analyst, Department of Health, Canada. Second edition; price $7.50. C. V. Mosby Company, St. Louis, 1926.

Shell Shock and Its Aftermath. By Norman Fenton, Ph.D., Associate Prof. of Psychology, Ohio University. Illustrated. Price $3.00. C. V. Mosby Company, St. Louis, 1926.

Diseases of Women. By Harry Sturgeon Crossen, M.D., Prof. of Clinical Gynecology, Washington University Medical School and Gynecologist in Chief to the Barnes Hospital and the Washington University Dispensary; Gynecologist to St. Luke's Hospital. Sixth edition, revised and enlarged, with 934 engravings, including one color plate. Price $11.00. C. V. Mosby Company, St. Louis, 1926.

The Normal Child and How to Keep It Normal in Mind and Morals. Suggestions for parents, teachers and physicians; with a consideration of the influence of psychoanalysis. By B. Sachs, M.D., New York. Price $1.50 net. Paul B. Hoeber, Inc., Medical Publishers, New York City.

History Taking and Recording. By James A. Corscaden, M.D., Associate in Obstetrics and Gynecology, Columbia University, New York. Price $1.50. Paul B. Hoeber, Inc., New York, 1926.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 153 Oneida Street, Milwaukee, Wisconsin. These new books will be loaned for an inspection period only.

Life Insurance Medicine. A study of some of its problems and their relation to clinical medicine by members of the medical department of the New England Mutual Life Insurance Company. Volume I, published by New England Mutual Life Insurance Co., Boston, 1926.

This book contains eight articles by members of the staff of the New England Life Insurance Co. All of the articles are very much worth while reading and some deserve much broader circulation.

The paper by McCrudden on "Occasional Slight Glycosuria" is the most comprehensive review of that subject that has come to the attention of the reviewer. It is really a splendid resume of this condition and the information given in a concise form is extremely well presented. A reprint of this article should be available in every medical library.

Another interesting paper in this book is on "The Cardio-Respiratory Test" by Frost. This test is an attempt to more accurately estimate the cardio-vascular function, and consists in subjecting the patient to a cardio-vascular strain which can be fairly well measured and which can be applied months or years later under approximately the same conditions and with approximately the same degree of severity. In view of our increasing death rate from "heart diseases," and bearing in mind the increasing popularity of the "Periodic Physical Examination" this cardio-respiratory test should have valuable possibilities.

Two other papers along the same line are by Frost on "Hypertension and Longevity" and the other by Amiral on "The Reaction of the Diastolic Pressure to Respiratory Strain," are intensely interesting.

It is refreshing indeed to note that some of these life insurance companies apparently appreciate that the extensive experience of their medical departments should not be tied up in statistics alone. The medical profession needs help along research lines and this book is apparently a move in the right direction.—O. L.

Young's Practice of Urology. Based on a study of 12,500 cases. By Hugh H. Young, M.D., and David M. Davis, M.D., Johns Hopkins University, with the collaboration of Frankin P. Johnson. Two octavo volumes totaling 1484 pages with 1003 illustrations, 20 being color plates. Per set: Cloth, $25.00 net. W. B. Saunders Company, Philadelphia and London.

Young's Practice of Urology, written in two volumes, fills the demand for a work in the English language in a rapidly advancing specialty. The urologist and general surgeon as well will be impressed by the originality of the work. It is a departure from the usual text book in that it is based on an immense experience in 12,500 cases. The arrangement is also different, the various chapters being arranged and diseases grouped with the purpose of establishing in the reader's mind a practical conception of the anatomy and physiology in order that pathological conditions may be better understood. For

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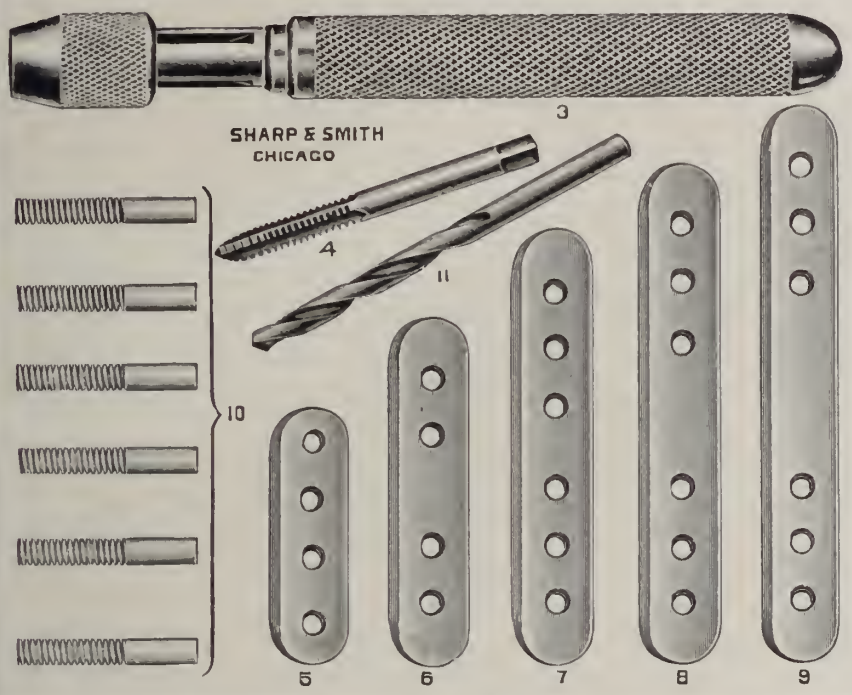

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See pages 637-640 Surgery, Gynecology and Obstetrics, May, 1914.

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instance the physiology and pathology of micturition are dealt with in the first chapter in a most elucidating way. The second chapter considers obstructive uropathy which includes all obstructing conditions in the urinary tract and the pathological sequelae which develop. The management of these conditions is treated in a logical manner.

The various methods and instruments of investigation and treatment and their relative merits are ably discussed. The senior author is singularly wrapped up in the development of urology both in this country and abroad. His mechanical genius has helped contribute many of the instruments of precision used in modern urology.

To those doing surgery the description of operations and technique will be most valuable. All urological operations are described together under the headings of the various organs and not after diseases.

The work is a permanent contribution to urological literature. It contains a concise historical review of the literature in every instance and has always in mind the demonstration of progress. Every urologist and general surgeon will do well to have these volumes in their libraries and the internists, too, would find it a valuable aid.—W. M. K.

The Human Cerebrospinal Fluid. An investigation of the most recent advances, as reported by the Association for Research in Nervous and Mental Disease. The proceedings of the association; New York, December 29th and 30th, 1924. With 77 illustrations and 58 tables. Paul B. Hoeber, New York, 1926.

This book is No. 4 of the series published by the Association for Research in Nervous and Mental Disease. As is true of the previous volumes it is a most comprehensive and splendid piece of work. It covers all aspects of, not only the spinal fluid examination, but the entire physiology and pathology of the cerebrospinal circulatory system. It is by far the best book on this subject known to the reviewer and should be in the library of every neurologist, internist and laboratory worker.

—B. B. R.

Report on Third International Congress of Military Medicine and Pharmacy. Paris, April, 1925. By Commander William Seaman Bainbridge, M.C., United States Naval Reserve Forces, Member of Permanent Committee, Delegate from the United States. Reprinted from The Military Surgeon, May to August, 1926, inclusive, Washington, D. C.

Commander Bainbridge has made a splendid report of each of the three International Congresses in Military Medicine; the first held in Brussels upon invitation of the King of Belgium in 1921; the second held at Rome in 1923; and now the third which met in Paris in 1925.

The Paris congress approved a resolution for the formation of an International Association of Military Surgeons to be framed at the next congress on Military Medicine to be held in Warsaw, Poland, in 1927. These congresses are of the utmost significance and importance and Commander Bainbridge has performed an exceedingly valuable service in making the proceedings available to the medical profession and others interested through the medium of these very excellent reports.

The basic reason for the congresses and for the publication of the proceedings is to make the lessons of the last war of the greatest value to humanity not only as a guide in preparation for the care of the sick and wounded in the next war, but to apply the lessons so far as they may be appreciable to the medical problem of peace time. The lessons of the last war were too costly for the world to forget them or to fail to profit by them.

These excellent reports contain much valuable information particularly to those who desire to keep abreast of the latest information on military medicine and surgery.—G. E. S.

The Normal Child and How to Keep It Normal in Mind and Morals. Suggestions for parents, teachers and physicians; with a consideration of the influence of psychoanalysis. By B. Sachs, M.D., New York. Price $1.50 net. Paul B. Hoeber, Inc., Medical Publishers, New York City.

This is a short treatise on the mental health of Infants and children. One-third of the book is devoted to a condemnation of psychoanalysis and is a plea for the abandonment of the method. While the book is interesting reading, it is too short to be of much help to physicians, but may possibly be of some value to parents. The author is to be commended for his common sense ideas and it would be very interesting to read a longer book by him on the same subject, in which he would cite specific case histories and give details as to treatment.

—R. M. G.

Diseases of Women. By Harry Sturgeon Crossen, M.D., Prof. of Clinical Gynecology, Washington University Medical School and Gynecologist in Chief to the Barnes Hospital and the Washington University Dispensary; Gynecologist to St. Luke's Hospital. Sixth edition, revised and enlarged, with 934 engravings, including one color plate. Price $11.00. C. V. Mosby Company, St. Louis, 1926.

The first edition of Dr. Crossen's Diseases of Women was printed in 1907, the sixth edition, which is revised and again enlarged has just come from the press. The text is clear and concise, and new material has been added under a number of subjects to bring them up-to-date. The use of iodized oil for x-ray visualization of the uterine and tubal cavities is described in detail. The practitioner as well as the medical student will find a wealth of conservative information regarding gynecological diagnosis and treatment in this handsome volume.—C. H. D.

Surgical Clinics of North America. Vol. VI, No. 4, Mayo Clinic Number, October 1926. Pages, 274 with 91 illustrations. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

This volume of the Surgical Clinics contains a variety of articles, some are the results of studies upon the bile and bile formation which have done so much to clarify our conceptions of this most important secretion; some are case reports with comments upon some unusual conditions. The suture of blood vessel is also described.

The Wisconsin Medical Journal

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Periodic Physical Examinations in Children of Pre-School Age*

BY J. GURNEY TAYLOR, M.D.
Milwaukee

The institution of periodic physical or health examinations in children of this age group has received increasingly more recognition within the past few years.

Preventive medicine includes in its periodic examinations first, the infant group; second, the pre-school age; third, the school age, and lastly, the adult.

For many years the infant and school age groups have been carefully supervised, educational pamphlets containing directions to the Nth degree have been published, clinics established and extensive welfare care provided. The school child again is provided for by well regulated standardized examinations and efforts attempted to correct beginning or established physical defects and further education of the parents.

The pre-school age children from one to six years, however, has constituted the group where the least constructive work has been accomplished, and which, therefore, claims our special consideration. Is it not a fact that most of the children of this age group receive the attention of the physician, in the main, only at the time of an illness, accident, or possibly a vaccination or immunization?

The importance of the pre-school age period stands out prominently inasmuch as at this time there is a rapid physical growth, the habits are materially changed, those of an active child are established; their immunity is not highly developed and illness is a frequent manifestation. Another fact, not so frequently mentioned but fully recognized, is that from 40 per cent to 45 per cent of the children of school age are found, by the surveys that have been made on entrance to school, to possess definite physical defects, some of which may have developed during infancy or even later. There is no question that a certain portion of these defects are remediable and others preventable.

It is just as important therefore that regular periodic health examinations be made of these children. The purpose of these examinations is twofold. It is concretely and excellently expressed by Veeder (Journal A. M. A. September 4, 1926, page 779.) "It recognizes the incipient physical defects or disease, which is the primary purpose of the adult periodic health examination and in addition it is a method of watching and measuring the development of the child which is of equal importance from the standpoint of preventive medicine in childhood years."

We furthermore recognize that during this formative age regular care, control, and observation should be the privilege extended to every child in order that we may accomplish the maximum of benefit in the prevention of many conditions which are subject to correction.

Today the value of the periodic or physical health examination has grown in direct proportion to the salesmanship that has been instituted. The public has been educated more and more in regard to the necessity of it, through its being broadcast by the press, radio, and many other agencies. And the physicians are awakening to the demands of the public for service of this kind.

I present for your consideration a chart recently devised by Veeder. It is essentially a development record as its caption denotes. (A. M. A. Journal, September 4, 1926, page 779-80.)

Case for Examination

The physician has presented his own child for examination at this time. Incomplete records have been submitted of the child's previous history and only a few minutes was allowed for examination previous to presentation of this paper, therefore, we will go over together a hurried examination. On account of the temperature of the room, I feel that it is undesirable to have the child stripped for any length of time.

I find in this child, first, that it was not quite a full term infant, having been three weeks premature. The birth weight was 6 pounds and 4¾

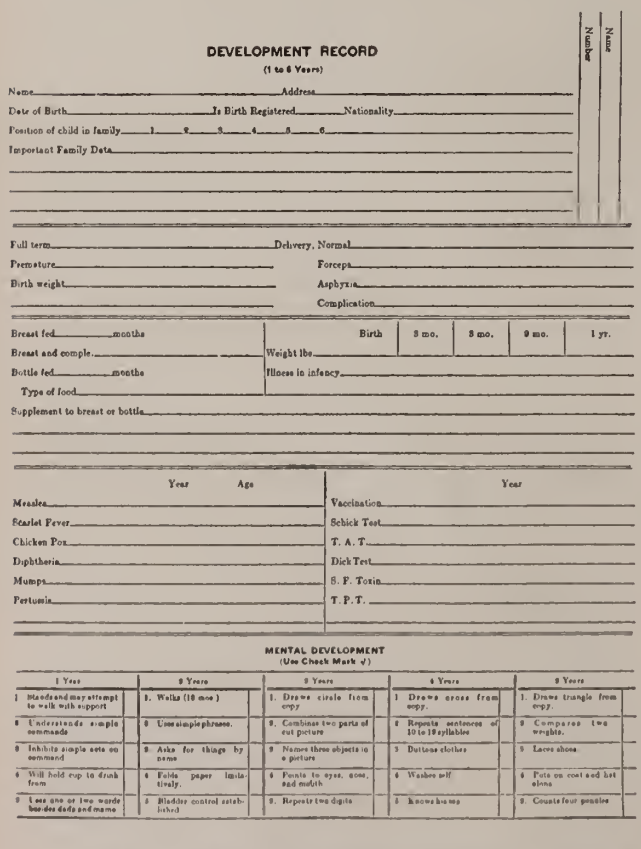
*Presented before 85th Anniversary Meeting, State Medical Society of Wisconsin, Madison, September, 1926.

ounces and was a normal delivery. The infant was breastfed solely for two months, breast and complementary feedings four months, and bottle fed at seven months. The type of food was pasteurized milk, dextromaltose, farina, cod liver oil, orange juice, tomato juice from the age of three months and one egg daily after six months.

The eruption of teeth was between five and six months and was normal. He had been vaccinated for smallpox and in 1923 was given the typhoid vaccine. The mental development was normal and for an infant four years of age, we were able to check off the complete record as presented under mental development. The height was not presented by the father but the weight at eight months was 37 pounds, which is above the mean weight as denoted by the middle line in our weight chart. In securing history we find that the tonsils and adenoids were removed at two and one-half years of age; urine examination was normal; blood had not been examined; there was regularity in all habits and the only disturbing factor at this time being an anuresis.

In our examination we begin at the scalp and find nothing abnormal; text of hair fine; ears negative, no enlargement of cervical, axillary or inguinal glands; teeth are regular and all present for this age; tonsils and adenoids removed and no abnormal findings in his mouth. The eyes were apparently negative; the skin is clear; nutrition is good; the thyroid negative; the chest well developed with apparently a little thickening and prominence of costal borders, and possibly a suggestion of a little depression above same (Harrison's Groove). This child was not entirely breastfed, as we have noted, therefore the possibility of this skeletal disturbance. The heart and lungs were negative. There were no physical defects noted on arms or legs; no flat feet or any other variation from normal. The testicles were descended and his musculature was fair. All reflexes were apparently equal and active.

Our conclusions, therefore, are that this child is normal in every respect and our advice is to



DEVELOPMENT RECORD
(1 to 6 Years)

Name ____ Address ____
Date of Birth ____ Is Birth Registered ____ Nationality ____
Position of child in family 1 2 3 4 5 6
Important Family Data ____

Number | Name

Full term ____ Delivery, Normal ____
Premature ____ Forceps ____
Birth weight ____ Asphyxia ____
Complication ____

Breast fed ____ months
Breast and comple. ____
Bottle fed ____ months
Type of food ____
Supplement to breast or bottle ____

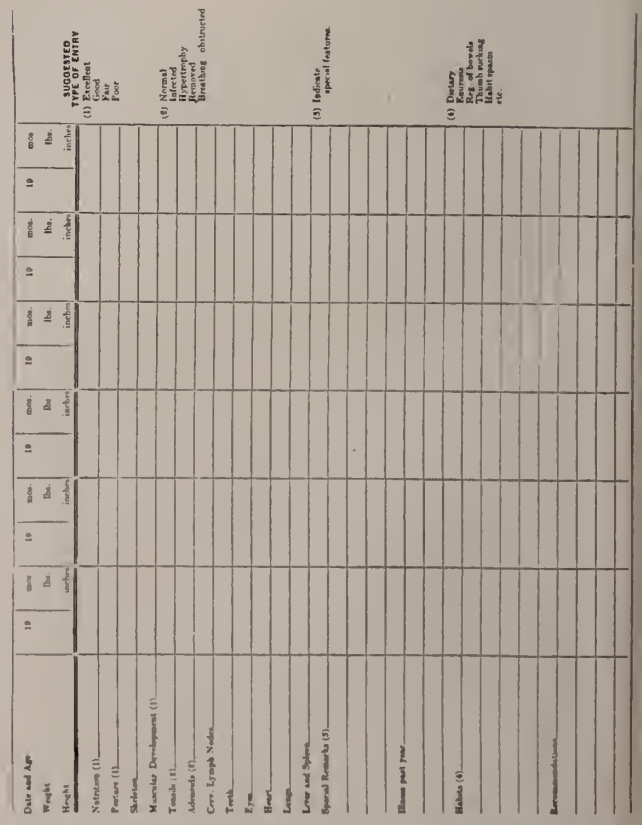
Birth	3 mo.	3 mo.	9 mo.	1 yr.
Weight lbs.				
Illness in infancy				

Year Age	Year
Measles	Vaccination
Scarlet Fever	Schick Test
Chicken Pox	T. A. T.
Diphtheria	Dick Test
Mumps	S. F. Toxin
Pertussis	T. P. T.

MENTAL DEVELOPMENT
(Use Check Mark √)

1 Year	2 Years	3 Years	4 Years	5 Years
1 Stands and may attempt to walk with support	1. Walks (18 mos.)	1. Draws circle from copy	1 Draws cross from copy.	1. Draws triangle from copy.
2 Understands simple commands	2 Uses simple phrases.	2. Combines two parts of cut picture	2 Repeats sentences of 10 to 12 syllables	2 Compares two weights.
3 Inhibits simple acts on command	3 Asks for things by name	3 Names three objects in a picture	3 Buttons clothes	3 Laces shoes
4 Will hold cup to drink from	4 Folds paper imitatively.	4 Points to eyes, nose, and mouth	4 Washes self	4 Puts on coat and hat alone
5 Uses one or two words besides dada and mama	5 Bladder control established	5. Repeats two digits	5 Knows his sex	5. Counts four pennies

Fig. 1. Page 1 of the development record: Space is furnished for important data during the period of infancy, and, in addition, record space for the exanthems and for immunization. At the bottom, simple tests of mental development are shown, the latter being only sketchy and covering only a few of the essential things a child should be able to do at a given age. (Courtesy J.A.M.A.)



SUGGESTED TYPE OF ENTRY
(1) Excellent Good Fair Poor
(2) Normal Infected Hypertrophy Removed Breathing obstructed
(3) Indicate special features.
(4) Dietary Enuresis Reg. of bowels Thumb sucking Habit spasm etc.

Date and Age | Weight | Height | Nutrition (1) | Posture (1) | Skeleton | Muscular Development (1) | Tonsils (1) | Adenoids (1) | Cerv. Lymph Nodes | Teeth | Eyes | Heart | Lungs | Liver and Spleen | Special Remarks (3) | Illness past year | Habits (4) | Recommendations

Fig. 2. Page 2. A simple form for recording the examination of the chief points encountered at this age period, and intended for brief remarks. (Courtesy J. A. M. A.)

have these periodic examinations repeated regularly at least once a year.

Before entering into further discussion of conditions to be looked for, I would like to discuss this chart as a record form. I believe it gives to us, at the present time, the best outline we have and one by which comparative observations may be readily recorded from time to time.

It may be that the physician will desire to add or subtract from it according to his own personal requirements but it contains a most substantial outline for the recording of findings.

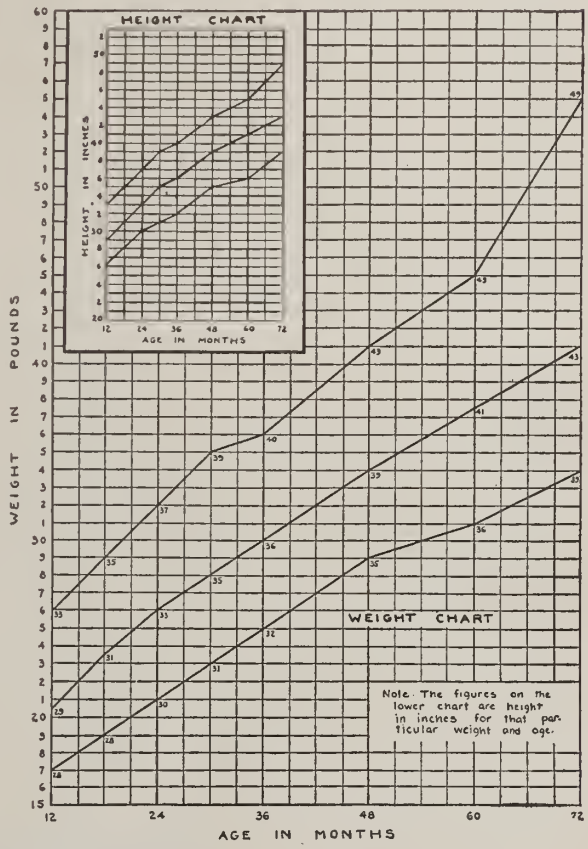
1. In making these examinations, I believe we should have before us some general outline of thought and we might consider first nutrition. This enters most frequently into the picture. A child who has not received the proper diet and therefore has a resultant dyspepsia which has developed in early life, most frequently leaves an imprint on the entire body structure which is clearly seen by a careful examination.
2. The skeletal findings.
3. Tuberculosis and its complications.
4. The lymphatic system.
5. Any active contagious or other diseases.
6. The effects of contagious diseases, such as, the paralysis resulting from diphtheria or nephritis from scarlet fever or tuberculosis following the footsteps of measles or pertussis.
7. Paralysis such as might be the after effects of an anterior polio.
8. The mentality and its variations from normal.

The Routine

Careful examination of the urine, including microscopic, should be carefully made in every examination. The omission of carefully repeated examinations of stools may be the cause of our downfall; intestinal parasites may be a disturbing factor, correction of which might help to clear a persistent anemia. Therefore, the importance of making regular blood examinations is to be stressed. This should include the Wassermann.

The many possibilities of systemic infection, with their bearing on the nutrition problem, should receive extremely careful visualization. Is it not just as important to rule out the possible chronic appendix, correct the chronic otitis media, definitely infected tonsils and adenoids, a pyelitis, a cystitis, the carious teeth, or a possible tuberculosis of glands or bones, as well as other possibilities?

The teeth of the growing child which are carious are definitely a factor which should receive our strenuous advice. Too often children are sent to the dentist who absolutely refuses either from ignorance or lack of desire, to have them in his chair, or some other complex unexplainable, to remove foci of infection which are definitely seated in a carious tooth or teeth. The child is repeatedly returned with a notation that he must carry these harbors of infection until the second teeth erupt. I feel that this has been a serious condition in many of our acute cardio nephritic cases as well as our many cases of articular involvement,



Based on Woodbury, Weight-Height-Age Tables
American Child Health Association
370 Seventh Ave., New York City

Fig. 3. Page 3: Two specially drawn charts permit the recording of growth as measured by height and weight. On each chart the center line is an average for boys and girls, the upper and lower lines being average extremes. A child, aged two years, weighing 27 pounds (12 kg.), would be recorded on the weight chart by a mark at the point at which the vertical age line and the horizontal weight lines cross. The height in inches is recorded in figures at one side, and a glance will show whether the child is average weight for height. In this case the average height should be about 34 inches. If, for example, the height is under 33 inches, the chart would show that the weight is above average; and if the height is 37 inches, the child is obviously below average weight for his height. Subsequent measurements, made from time to time, would be connected by a line giving the gain of growth and development. The child's height may be marked on the height chart and the points connected by a line in a similar manner. (Courtesy J.A.M.A.)

therefore the physician should not fail to see that the child's mouth is properly investigated and corrected. It is a safeguard to the child's future health which never should be neglected.

I would urge therefore that these examinations be conducted along the same rigid, careful lines as laid down for the adult; that the regular periods of examination be instituted; that the importance of these examinations be impressed upon guardians, caretakers, and parents, and, that children, who show material defects which are corrective, be properly directed, and above all be kept under constant periodic examination in order to ascertain whether their treatment has been properly carried out.

It is only through the consistent production of good results that the parents will become convinced and hence educated.

DISCUSSION

Dr. H. F. Helmholz (Rochester, Minn): This very important topic of health examinations, particularly in the pre-school child, I feel deserves the attention of every practitioner, because it is your duty to follow these children through until the school period. Just as we all realize now that it is a medical problem to take care of the feeding and hygienic care of the infant, so should this be extended to the school age period. We, as physicians, must realize that it is our duty, not as a public health problem, but as the public health part of our duty as physicians, to care for the infant. The first two years the care of the normal infant is part of our medical work. I feel we ought to continue up to the school age to make it a part of our work to see that those defects that are developing are taken care of before they give actual clinical symptoms. That is part of the work of every medical man—to take care of all the children in his practice during that pre-school age period.

HOME WEIGHING RECORD

	19	19	19	19	19	19
January	lbs.	lbs.	lbs.	lbs.	lbs.	lbs.
April	lbs.	lbs.	lbs.	lbs.	lbs.	lbs.
July	lbs.	lbs.	lbs.	lbs.	lbs.	lbs.
October	lbs.	lbs.	lbs.	lbs.	lbs.	lbs.

Fig. 4. Table on page 4. Below this is space for notes. and suggestions for using the development record.

Fractures of the Skull*

BY ERNEST SACHS, M.D.

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St. Louis, Missouri

Since the great increase in head injuries as a result of the large number of automobile accidents, it has become more important than ever before for the general practitioner, as well as the surgeon, to have a clearer understanding of the problems involved. Though the subject is discussed in every text book of surgery, I have found that all of these treatises devote too much time to theoretical considerations and not enough to the practical side of the question. Every text book article devotes much time to the mechanism by which fractures are produced, yet that is of little if any value to the physician faced with a case of head injury. In teaching my students I have found a different approach much more satisfactory.

The first and most important point always to keep in mind in every fracture of the skull is what has happened in the intracranial cavity.

All the possibilities may be grouped under six headings:

1. Compound fracture of the skull with and without rupture of the dura.
2. Simple depressed fracture.
3. Intracranial hemorrhage.
4. Contusion and laceration of the brain.
5. Oedema of the brain.
6. Rupture of the arachnoid with escape of cerebro-spinal fluid into the subdural space.

These we shall now take up in succession.

COMPOUND FRACTURES

These are to be dealt with as are lacerated wounds anywhere else in the body. All the soiled, contaminated and devitalized tissue is to be excised. Bone fragments that are soiled should be removed; if attached to dura, so that they may live, they may be saved. Since the bones of the skull do not regenerate except in children and young adults, and since keeping bone is not as essential as in a fracture of a long bone where they are needed for weight bearing and movement, fragments may be sacrificed with greater impunity. Then, too, if an infection were to result in an extremity due to incomplete debridement, the worst we may get is an osteomyelitis, but if infection follows a compound fracture of the skull, especially if the dura was open, meningitis or brain abscess

*Presented before 85th Anniversary Meeting, State Medical Society of Wisconsin, Madison, September, 1926.

are almost the inevitable result. Therefore we must aim to debride completely, stop all hemorrhage and close head wounds *without drainage.* If the dura has been torn and the brain lacerated, the traumatized dura and the lacerated brain tissue must be excised. This may be a formidable operation for it necessitates a knowledge of how to handle brain tissue and control the bleeding from cerebral vessels.

It is in the care of these wounds that I have most frequently seen errors made. Drainage is always considered essential whereas I believe it to be the greatest menace to a successful result in these cases. If infection should develop due to an incomplete debridement or one that has been undertaken too late, working through a clean skin field will be an advantage.

After several months these cases frequently have to have a bone transplant using the outer table of the skull as described first by Wagner, but we do the operation somewhat differently; Wagner chiseled off the outer plate with periosteum attached and moved it into the defect so that the roughened bone lay against the dura or brain. We turn it over like the leaf of a book so that the smooth periosteum lies against the brain or dura, and if this method is employed it may do away with the necessity of transplanting fascia to replace a defect in the dura.

The neurological symptoms of the compound fracture do not come into consideration. The problem is one of preventing infection.

SIMPLE DEPRESSED FRACTURES

These should be operated upon as soon as possible regardless of whether they present neurological symptoms or not. A depressed fracture is always a potential source of future trouble. The patient with a depressed fracture is more likely to develop traumatic epilepsy than any other and though traumatic epilepsy occurs in but a small percentage of fracture cases (10-15 per cent) it must be reckoned with. There are cases of course in which for some reason the elevation of the fracture must be delayed, as for instance a scalp into which dirt has been ground so that a clean operative field cannot be assured, or severe shock, but as soon as these factors of danger can be controlled the fracture should be elevated.

INTRACRANIAL HEMORRHAGE

The classical picture of a rapidly developing intracranial hemorrhage is well known. The individual receives a blow on the head and is unconscious for a moment or brief period. He then regains consciousness and seems normal, may be able to talk intelligently, and then gradually becomes drowsy and finally unconscious and may develop a partial or complete paralysis on the side of the body opposite to that on which the hemorrhage is taking place, i. e., a right cerebral hemorrhage causes a left-sided paralysis, and vice versa. Occasionally they have Jacksonian convulsions. In addition these cases may have a slow pulse and irregular respirations. The period of regained consciousness is spoken of as the "lucid interval." Its length varies with the severity and rapidity of the hemorrhage. If in this type of case *frequent* blood pressure readings are made (every fifteen minutes) the blood pressure will be seen to rise in steps. This progressive rise in blood pressure is absolutely diagnostic of a progressing hemorrhage and is an absolute indication for immediate operation. In order to recognize the condition early, it has become routine to take frequent blood pressure type of lesion is comparatively rare, rupture of the middle meningeal artery when recognized and treated at once, yields most satisfactory results. It is of great interest also to remember that rupture of the middle meningeal artery may occur without an associated fractured skull. The question frequently comes up, how shall one know the side on which the hemorrhage is occurring? This must be determined by a careful neurological examination. The pathological reflexes or a paresis of one side of the face or an extremity should be the guide and *not the site of fracture.* If a middle meningeal hemorrhage is diagnosed it can be dealt with through a vertical subtemporal decompression incision.

It may appear to some of you that I am advocating operation in fractures of the skull since in the three conditions I have thus far discussed I have advised operation. These three conditions, however, constitute but a small percentage of all fracture cases. I have discussed them first because they were simpler to dispose of and because practically every one is agreed as to the treatment. Fully fifty per cent, however, of cases of fractured skull fall into the next two groups and for these cases operation is rarely required.

CONTUSION AND LACERATION OF THE BRAIN AND CEREBRAL OEDEMA

The majority of patients with head injuries are

brought in in various stages of unconsciousness, they may be bewildered, they may have a brief period of unconsciousness, or they may have a prolonged period of unconsciousness which sometimes lasts for days or weeks. These patients may show a fracture of the vault or base of the skull and show some neurological signs, irregular pupils, pathological reflexes on one or both sides, a slow pulse, irregular or Cheyne-Stokes type of respirations, much more rarely convulsions. The blood pressure in these cases does not rise unless there is an associated progressive hemorrhage. These patients have lacerated brain tissue with some hemorrhage but no large vessel bleeding. The severity of the symptoms depends on the amount of contusion and laceration and also upon the amount of cerebral oedema. No tissue of the body becomes oedematous as rapidly as the brain on account of its peculiar physical properties. The symptoms that this group of cases presents are for the most part due to the oedema which produces a marked increase of intracranial pressure. The problem in these cases therefore is to deal with the cerebral oedema. This may be done in one of three ways: First, shrinking the brain tissue; second, removing fluid from the brain cavities to give the oedematous brain more room, and third, to enlarge the cranial cavity so that the brain can expand. Of these three methods, the first, removing fluid from the tissues, is the most effective and now most frequently used. This may be done by giving hypertonic fluids intravenously; saturated salt solution 33 per cent, or 50 per cent glucose solution. Of the salt solution, one uses up to 60 c.c. at the rate of 1 to 2 c.c. per minute; of the glucose solution, 20 to 40 c.c. at about the same rate or a little faster.

The same dehydration may be accomplished by giving magnesium sulphate by mouth or per rectum. The objection to the oral administration is that these patients very commonly vomit and therefore do not tolerate the magnesium sulphate. We give 50 per cent magnesium sulphate per rectum every 3 to 4 hours, making the patient retain at least 15 minutes.

The second method of removing cerebro-spinal fluid may be done by ventricle or lumbar puncture. The latter is very generally made use of, and far more frequently than is generally known is the cause of death. A few writers have drawn attention to this point but the procedure is still carried on. Where intracranial pressure is increased, removal of cerebro-spinal fluid by lumbar puncture may cause a dropping of the cerebellum on the medulla with respiratory failure. Fracture cases almost always do die of respiratory failure anyway and this is due to medullary involvement. I have seen three or four cases die as a result of lumbar puncture and therefore in my clinic this procedure is absolutely forbidden. If cerebrospinal fluid is to be removed, it should be done by ventricle puncture. As a matter of fact, the first procedure, shrinking the brain, is usually effective in these cases if anything is going to do any good. At times in addition to using hypertonic fluid, it seems desirable to give the brain during the period of oedema more room. In that case a subtemporal decompression is done but we are doing this less and less frequently as the hypertonic treatment is so uniformly effective.

I should like to say a word more, because I have been asked questions since I have been here and have frequently been asked questions, on the use of lumbar puncture in spinal fracture. My attitude about it is this: When it was first suggested about twenty or twenty-five years ago it was proposed as a diagnostic method, and the idea then, as suggested by Harvey Cushing, was that if you did a spinal puncture and found bloody cerebro-spinal fluid it was evident that the brain was contused and lacerated and there was a rupture of the arachnoid; on the other hand, if the cerebrospinal-fluid was clear there was not that sort of condition.

I maintain that it is perfectly possible when you see a case to decide what is the best method of procedure; you may not be able to decide it at once, you may have to do some tall thinking, but you can come to a decision, and that decision will not be influenced by the presence or absence of bloody spinal fluid. In other words, from a diagnostic point of view, bloody spinal fluid is not going to help you.

In the second place, I have had this personal experience and I have known of others who have had the experience, that there is a real danger in doing a spinal puncture in a fracture case because they may die immediately or they may die after a few hours as the cerebellum gradually sinks down on the medulla. Though this procedure is of help to one diagnostically from the point of view of treatment, it has an element of real danger, there-

fore I strenuously oppose the use of lumbar puncture in fractures of the skull.

All injuries of the brain may have cerebral oedema and consequently hypertonic fluids may be useful in the after treatment of any of the cases that fall into the first three groups.

RUPTURE OF THE ARACHNOID MEMBRANE

Within the last few years attention has been drawn to a group of cases that presents a picture not unlike that of middle meningeal hemorrhage except that they have no rising blood pressure. The clinical picture may be very alarming. They may have Jacksonian convulsions, unilateral weakness or paralysis and slow pulse. At operation the dura is very tense and on nicking it yellow or blood-stained cerebro-spinal fluid spurts out under great pressure. The intracranial pressure is immediately reduced and the patient makes a rapid, uneventful recovery.

I might cite a case that is perfectly typical. A boy skating about a mile from the hospital fell down and one of his friends in passing struck his head with a skate and the boy was unconscious. He was rushed to the hospital, and by the time he came in he was perfectly conscious. He told his name, his age, where he lived, and so on. The routine was followed of taking his blood pressure, which necessitated somebody being at the bedside almost continuously. The blood pressure, however, did not change. While the nurse was taking the pressure he had a convulsion of his arm and face on one side, the side opposite the one where he had been struck on the head. I was called up and came immediately; I got there within about five minutes after his convulsion. By that time he was dopey, could hardly be aroused, had developed a weakness in that hand, and while I stood there and was examining him he had another convulsion. Though his blood pressure did not go up very much, it went up during the convulsion, as it always does, but it did not go up a great deal. I concluded that he had a little meningeal hemorrhage and took him up to the operating room and opened him up. When I opened him up the dura was tense as a drum; there was no evidence of meningeal hemorrhage, no blood between the pons and the dura; the dura was tense, and when I nicked it, it spurted up about four or five feet, this column of yellow cerebro-spinal fluid. We lost the fluid and could not estimate how much it was. I should say it was anywhere from ten to thirty or forty c.c. Immediately the dura became collapsed. As a precaution I split the dura wide open and left a decompression opening.

That evening the boy was perfectly conscious. He has never had another convulsion. He was kept in bed for several weeks with much difficulty in keeping him quiet for fear there might be some more contusion and laceration that we did not see, but he cleared up and never has had any more symptoms. That was two or three years ago. That picture can very readily be confused with a little meningeal hemorrhage.

Before closing my remarks there are two matters that need consideration and explanation.

Not a word has been said about the difference in treatment and prognosis between fractures of the vault and fractures of the base of the skull. This I have done intentionally for, as I stated at the beginning, the important point is what has happened to the intracranial contents, not what has happened to the skull. I don't believe that fractures of the base have a much worse prognosis than vault fractures. I do believe the more severe the contusion and laceration of the brain, the graver is the prognosis.

Lastly, I have not used the term *concussion.* I do not believe there is a clinical picture that can be isolated as concussion unless it be the momentary unconsciousness with transient slow pulse that is seen when an individual, for example, is hit with a golf ball. He feels "groggy" for a few minutes and a bit dizzy but soon forgets all about it. Such cases do not die and therefore we do not know what the pathology of the brain is. But all cases that die, if carefully enough examined, show minute hemorrhages, and I prefer to call all these contusion and laceration.

There are just one or two lantern slides that I want to show you.

If you are going to operate, one of the things that is absolutely essential, I believe, is that no dura should ever be incised until the pressure has been reduced. I know of no cases, including tumors, in which you may see a greater increase of intracranial pressure without any evidence clinically than in cases of cerebral injury where there has been a marked contusion or laceration. Probably many of you are familiar with the appearance of the blue, tense dura. If that dura is incised, as it must be if you are doing a decompression, because that is the fundamental

principle of a decompression that the dura should be opened, before the intracranial pressure is reduced you are going to have a catastrophe, you are going to have a brain that protrudes and pours out, and immediately ruptures and goes all to pieces. Of course, you don't want to do that kind of decompression operation. You want to handle the brain with the greatest possible delicacy. To have a brain rupture is a calamity.

The way to reduce the intracranial pressure is by ventricle puncture. The two points of election and the easiest points are behind the ear, so-called Reed's point, about a centimeter above and behind the external auditory meatus, or through the center of any convolution.

In any decompression operation, the needle, a large needle with holes on the side, is inserted through a nick in the dura, into the inferior horn of the temporal lobe. If this very crudely represents the lateral view of the cerebrum, the ventricle is projected on the cortex something like this. (At this point the reader drew some diagrams on the Blackboard.) In a well-placed decompression operation this portion of the temporal lobe is exposed, the area below the fissure of Sylvius. In order to reach the ventricle through a decompression opening, you have to place the needle at a considerable angle. If you do that you have no difficulty in getting the fluid, collapsing the brain, and then have no danger in opening the dura.

The other point at which a ventricle puncture can always be done with very little or no danger and with very little difficulty is any place about a centimeter to one side of the median line of the longitudinal sinus. I personally believe that one never should do a ventricle puncture without seeing the cortex. Pediatricians do it by sticking a needle through the skin, which I thoroughly disapprove of. You may stick a needle into a vessel, and it has been done.

It sometimes happens, not as frequently in fracture cases as tumor, it is true, that you cannot get cerebro-spinal fluid out of the ventricle when the ventricle is collapsed; then you are in the serious condition of having to open the dura with a brain that is under tension.

In such a case place all your sutures in your temporal muscle before you open your dura, and then draw them aside. One retractor holds about six of them in one direction, and the other holds the other group. Then rapidly incise your dura and you can draw all the sutures up together and the assistant can hold them while you tie them rapidly. That is just a little surgical trick.

I realize perfectly that I have gone over this subject rather sketchily, but my idea was merely to try to emphasize what seemed to me to be the essential points.

DISCUSSION

Dr. R. C. Blankinship (Madison): I would like to ask Dr. Sachs in the case he describes with the convulsion if that would be an indication for operation providing the blood pressure is low and the case is probably progressing fairly well outside of the fact that he was having an occasional convulsion.

Dr. Ernest Sachs (St. Louis): I should answer that question no. What I mean is this: The mere occurrence of a convulsion I don't think is necessarily an operative indication, but the presence of a Jacksonian convulsion is always to my mind an evidence of a cortical irritation, and I would not say that if the patient had one convulsion I would operate, I would always wait to see whether the patient had a second. Then (unless there was some other contraindication that is not apparent from your question) I would explore that area, because I think it always means cortical irritation, and in a traumatic case in the vast majority of instances it either means a frank hemorrhage or a contusion and laceration of that area or, in the exceptional case, a rupture of the arachnoid. I certainly never would operate just on one convulsion.

Dr. Blankinship: Three or four?

Dr. Sachs: If they are focal I would think so.

Dr. W. A. Clark (Janesville): I should like to ask Dr. Sachs about the possibility of the restoration of pituitary function.

Dr. Ernest Sachs: When there has been a fracture through the skull?

Dr. Clark: Yes.

Dr. Sachs: I presume you have a particular case in mind. What evidence was there of disturbed pituitary function? Glycosuria?

Dr. Clark: No, polyuria. This boy was seven years old. He sustained a basal fracture about ten weeks ago and was unconscious for six days. About a week later he began to pass three or four quarts of urine in twenty-four hours.

Dr. Sachs: I have seen several cases of that sort, some immediately after injury and some several years later where there was presumably pituitary injury, and I think the pituitary function recovers, supposing, of course, that the polyuria is due to the pituitary, which I don't believe it is. You will pardon me for differing.

A few years ago an assistant of mine, Dr. McDonald, of Boston, did some work on this question to determine the metabolic changes due to pituitary removal, and he found that he could leave the pituitary absolutely intact (it may be a rather technical point) and if he made a little injury in the so-called hypothalamus he got polyuria, but that, of course, is really more of aca-

demic interest because it is immediately around the pituitary. The cases I have seen have all recovered. Some of them have had a transient polyuria or a moderate polyuria for a long time. What I have seen, however, is several years later these cases become enormously fat and present a picture of hypopituitarism suggesting that there has been a scar or some injury to the pituitary which has interfered with the function. It would be interesting to watch that boy and see what he is like in two or three years.

DR. CLARK: This boy's weight is much above any that he ever had before. He is six or eight pounds heavier and he is eating tremendously.

DR. SACHS: I think he is on the road. I think probably you can control his polyuria with hypodermic injections of pituitary extract.

Recent Progress in the Treatment of Cancer of the Mouth and Tongue*

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Carcinoma of the mouth and tongue constitute a group of cases that is very difficult to treat and whose end results have been unsatisfactory with the ordinary surgical and physical methods of treatment. Authentic reports place the incidence of malignant lesions of the oral cavity including the lip as eight per cent of all maligancies, and next in frequency to carcinoma of the female pelvic organs and of the breast.

Taking this large composite group of cancer patients, many are hopelessly inoperable when first seen by the physician and the surgeon. They present themselves late, despite the fact that the primary lesion is easily in view and reach of both the host and the doctor. It is also true that carcinoma of the oral cavity grows very rapidly in many instances, showing a high grade of virulence in its local invasion and in its regional metastases. The tissues harboring the neoplasm are active muscular structures with a rich blood and lymph supply. The tumors are vulnerable and exposed to constant trauma to a marked degree, and local infection is an early complication if it does not actually antedate the disease. And finally, probably the major factors in its clinical manifestations and in the rapidity of extension are its cellular structures and the degree of differentiation or lack of self-control as has been worked out by Broders of the Mayo Clinic.

In different surgical centers, the range of operability in cases of cancer of the mouth varies from 40 to 50 per cent, because of the local extension or because of irreparable glandular involvement, and many of the operable cases died subsequently of the disease. With such a serious problem before us, the surgeon must at all times lend his best efforts to approved departures from older methods if they offer promise or hope to increase the range of operability, safeguard fully the surgical mortality and morbidity, increase the percentage of cures, reduce the incidence of recurrences, and obtain the best palliative results possible in the incurable and hopeless cases. The admonition of Doctor Joseph C. Bloodgood[1] was most opportune when he said: "Physicians should know the real facts about the results in the operative treatment of cancer; if they do they will realize that the percentage of cures of cancer depends today more on improvements of the method and extension of the education of the public and the profession than on any extension of the operation or improvement in the treatment with roentgen rays or with radium." Dr. George A. Wyeth[2] reminds us that "Not all of surgery's failures can be laid at the door of faulty pathology. Too often the fault is in the operation itself."

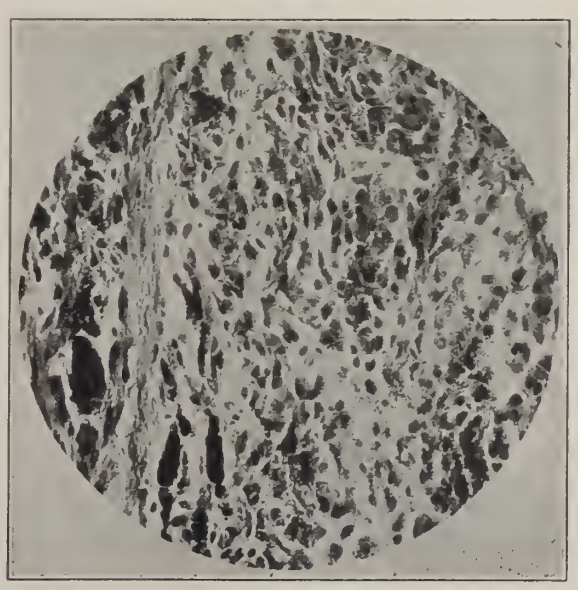

FIG. 1.
Melano-epithelioma of the mouth involving the gingiva and hard palate on the right side. One month duration. Operation bipolar endothermy August 27, 1925. Local recurrence and glandular metastases. Secondary operation October 8, 1925. Died March, 1926. General metastases.

*Presented before 85th Anniversary Meeting, State Medical Society of Wisconsin, Madison, September, 1926.

The surgical pathology of cancer of the mouth and tongue is generally well known. Time will not permit a lengthy discussion of it here. They are usually squamous epithelioma, of the ulcerative or the elevated fungating type, and involve the lip, the buccal surface, the floor of the mouth, palate, gingiva, tongue, tonsils or their pillars and pharynx. The antrum may be involved primarily or by extension from an adjacent oral lesion. Occasionally the intra-oral lesion is a papillary type of carcinoma which is much more favorable from a surgical standpoint. This type is found most frequently on the buccal surface and on the anterior lateral or mesial aspect of the tongue.

FIG. 2.
Melano-epithelioma entire half left upper lip with glandular involvement. Palliative x-ray treatment. Duration 6 months. Patient referred for excision of tumor of the lip as a palliative measure. Operation October 21, 1924. Excision of entire left half upper lip with endotherm knife under local anaesthesia and plastic closure of lip defect. Died December 19, 1924, of uremia without local recurrence in lip wound.

I have seen one case of primary squamous cancer at the junction of the right submaxillary salivary duct and the mucosa of the floor of the mouth, and a similar lesion at the junction of the left paratoid duct and the buccal mucosa. One of my cases was a melano-epithelioma of the mucosa of the gingiva and the hard palate which appeared promptly after the extraction of a tooth. (Fig, 1.) These cases are rare, there being only 25 authentic cases reported up to July, 1921. The malignancy may or may not have preceded the dental lesion. One other case was a melano-epithelioma of the upper lip in its left outer portion with glandular involvement. (Fig. 2.) In the past 6 months, I have seen two cases of squamous carcinoma of the tongue, complicating a long standing luetic glossitis. Primary carcinoma involving the floor of the mouth and of the tongue are considered more serious sites because of a higher grade of virulence and less accessible. The size of the primary lesion and lymphatic metasteses are not necessarily proportional to the duration. All these lesions tend to spread by continuity and by the lymphatic channels to the regional lymph glands. They frequently invade the bony structure of the mouth in neglected cases. One case of primary carcinoma of the left antrum extended upwards and involved the base of the skull in the region of the sphenoid bone and sella tursica with typical optic nerve and intra-cranial sequellae. (Fig. 3.) Squamous carcinoma superimposed on a patch of leucoplakia is frequently observed, and later occurrences in similar remote untreated lesions may be observed and for the same reason malignant lesions may be multiple. One of my cases of early epithelioma of the lower lip was in the site of a scar resulting from a successful operation for carcinoma of the lip done elsewhere nine years previous. (Fig. 4.) This is an example of a re-occurrence of carcinoma of which there are occasional authentic case reports. The gradation of malignancy is an important guide to the surgeon in the management of these diseases of the mouth and from the beginning can indicate to a degree the probable chances of glandular metastases and the necessity for prompt surgical excision. In the lip cases graded by Broders[3], 15.8 per cent were grade 1, 62 per cent grade 2, 21 per cent grade 3, and 1.1 per cent were grade 4. It is well known that cancer of the lip is much less virulent than those within the oral cavity. Of the lip patients operated on and traced at the time of the report in 1920, 59.5 per cent were alive. Of the patients who died of epithelioma none were of grade 1, 54.9 per cent of grade 2, 84.21 per cent of grade 3 and all the grade 4 were dead.

There are many facts and conditions that are known or are assumed regarding the etiology of carcinoma of the mouth and the tongue. It occurs in males in 88 per cent of the cases and is primarily a disease of later life. The majority of cases are found in the fifth and sixth decades with another smaller group after seventy years of age. Lip cases are frequently much younger and carci-

noma secondary to luetic glossitis is seen at times in the fourth decade. Chronic oral sepsis and chronic local irritation or trauma from any cause are almost invariably present. The trauma and mechanical irritation of sharp spicules of teeth are very frequently present at some time antedating the onset of the malignant ulcer. Poorly fitting dentures may be a source of chronic local irritation and I have seen several cases attributable to this factor. (Fig. 5.) Other allied causes are the injuries from thermic and chemical agencies including the use and abuse of tobacco in all forms and long continued disturbances of function and of structure. Carcinoma may develop in the margin of a patch of leucoplakia which is the result of chronic irritation from many sources. Chronic luetic glossitis and the scars or margins of an active tertiary gumma may be a favorite site for the development of carcinoma. The experience of some authors shows as high as 14 to 16 per cent incidence of a preceding luetic infection. (Fig. 6.) Tausig's advice is to be alert for superimposed carcinoma of the tongue in a gumma there that does not respond satisfactorily to competent anti-leutic therapy. There is considerable evidence to show that in some cases heredity plays a prominent role that may account for some of the cases whose cause is indeterminate. Benign neoplasms and inflammatory processes within the month from any sources may be forerunners of a malignant process.

The differential diagnosis of carcinoma of the oral cavity must be made from a large number of lesions, common in these structures. The latter may be divided into three principal groups and listed briefly: (a) Granulation tissue due to simple infections or persistent trauma or a foreign body may possibly simulate malignancy grossly. Leucoplakia, kerotosis and other degenerative changes as a result of chronic irritation must be excluded. Their recognition grossly will be less difficult than that of determining a transition into a malignant process. (b) Another inflammatory group includes specific glossitis, in the forms of a primary luetic ulcer and solitary or multiple gummata which may be degenerating and broken down. Carcinoma complicating syphilis or a sequel of it must be remembered. Tuberculoma or tuberculous ulcer (Fig. 7.) and actinomycosis or allied fungus infections must be excluded, but occasionally the latter are superimposed on an abraded malignant lesion. (c) A third group are the benign neoplasms and the malformations of the oral structure, including fibroma, lipoma, adenoma, angioma, osteoma, mixed tumors, aberrant thyroid, retention cysts epulis and ranula.

Complete clinical, serological, roentgenological and microscopic findings go to make up the probable diagnosis and eliminate many lesions without difficulty in the majority of cases. Biopsy in doubtful cases should be performed promptly for it can be carried out without hazard to the patient with the endotherm knife. Biopsy and early diagnosis of the primary lesion or questionable regional lymph glands are much preferred to loss of valuable time and uncertainty in the prompt recognition of malignancy in its early and favorable stages for treatment and cure. The grade of malignancy should be ascertained if possible at the outset. The so-called therapeutic test for Lues in cases of probable malignancy with our present methods of exact and prompt differentiation is mentioned only to condemn it. Cases calling for extensive operations and those entailing a hopeless prognosis in which radical treatment is contraindicated clinically had better be checked up microscopically whenever possible, unless the evidence is wholly conclusive.

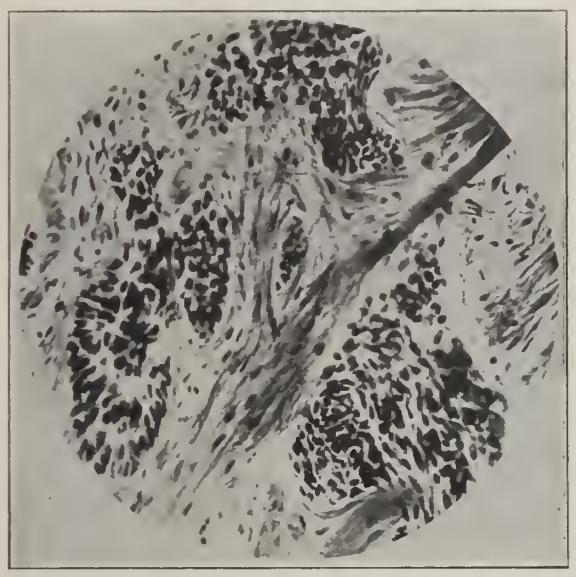

FIG. 3.
Epithelioma of the left upper gingiva and antrum. Patient had had previous cautery operation elsewhere 1 month subsequent to the extraction of a tooth. Referred for endothermy operation which was performed August 27, 1925, under general anaesthesia. September 1 and September 5, 1925, radium packs into antrum as an adjunct to the surgical treatment. Patient subsequently developed manifestations of metastases to the bones of the skull and the left cervical glands. Died approximately 5 months from time disease was first recognized.

In considering the treatment of any malignancy

it naturally divides itself into several sub-headings: Prophylactic treatment, the treatment of the primary lesion, the treatment of glandular involvement, the treatment of local accessible recurrences, and the treatment and management of the inoperable cases with palliative measures.

PROPHYLAXIS

The early and diligent examination of patients' mouth conditions and complaints by members of the medical and the dental profession are imperative and a proper significance and interpretation placed upon the findings. This carries with it a responsibility that we be thoroughly acquainted with the pathology and symptomatology of the

FIG. 4.
Re-ocurrence of epithelioma of lower lip 9 years after operation on lower lip and cervical glands elsewhere for carcinoma. Operation April 10, 1924. Bipolar endothermy under local anaesthesia. No recurrence Jan. 10, 1927.

lesions of the oral cavity, both inflammatory and neoplastic, benign and malignant. Dental hygiene and dental treatment, correction of abuses of tobacco and other management on a basis of known and supposed exciting causes of malignancy should be emphasized. A prompt direct surgical attack on so-called precancerous lesions should be carried out wherever necessary and possible. Bloodgood has pointed out that the mouth should be a particularly favorable locality for preventive work, because we have the correct information which will prevent many if not most cases of oral cancer. To facilitate this phase of treatment, widespread education and propaganda are necessary to get better co-operation and response from the medical and dental professions and from the lay population.

TREATMENT OF THE PRIMARY LESION

Early examination of the host and prompt positive treatment are the most important factors in all malignancies. Bloodgood summarizes the whole problem very well when he says: "It is justifiable to-day to state that the chances of curing late cancer are as relatively small as the chances of curing early cancer are relatively large." Taking this whole group of malignancies as they present themselves to us, a direct surgical attack upon the primary lesions offers the best chances of recovery, when the lesion is accessible and not too far advanced or extensive locally and if regional and remote glandular metastases have not reached the stage that would defeat and defy the purposes of any form of treatment. Ewing, with the experience and the vision of a great pathologist, has said that surgery is the only reliable method of treatment that can now be generally recommended in the treatment of malignancy, but radiation is of great value in many and is to be preferred in some cases. Dr. Joseph C. Bloodgood recently said: "I have had a large opportunity to compare radiation with local excision in the early stages of cancer of the mouth, and my own experience forces me to the conclusion that excision with the cautery is the safer procedure."

ENDOTHERMY

The results with ordinary surgical measures or methods have been for the most part unsatisfactory. A better method than excision with the scalpel is the destruction of the lesion with heat. (Fig. 8.) The cautery has been displaced by an improved surgical agency in the form of endothermy. It has many advantages that other methods do not possess. Its contraindications and disadvantages are clearly understood. With endothermy many growths of the mouth and tongue can safely be destroyed that formerly would be classed as inoperable, and the mortality with this method should be practically nil as compared with a high surgical mortality accompanying former surgical methods. Splitting of the cheek or the ramus of the jaw have not been found necessary in using endothermy. Preliminary ligations of ves-

FIG. 5.
Extensive fungating epithelioma of the hard palate and buccal mucosa of 1 year's duration. Patient had worn a dental plate for 10 years. Right antrum also involved. Bipolar endothermy of lesion, including the left antrum, October, 1926. December 15, 1926, bipolar endothermy for small area of local recurrence. General anaesthesia.

sels is usually necessary to safeguard against secondary hemorrhage.

While a comparison of the results with the older surgical methods of scalpel and cautery are more favorable than those obtained with physical measures alone, the results in the operable cases are not satisfactory because of the frequency of local and remote recurrence, high mortality and morbidity and because only a relatively small number of the cases are operable. This dissatisfaction and disappointment, with the results from former surgical methods and the more definite limitations with physical agents in the treatment of malignant lesions generally, and of the mouth and tongue particularly have led to the develpoment and improvement of electro-thermic measures of heat destruction which promise to improve our immediate end results to a marked degree. In America, this departure from the older surgical methods of excision and destruction with the scalpel and the cautery has been advocated and practiced more particularly by Dr. Wm. L. Clark of Philadelphia, and more recently by Dr. Geo. A. Wyeth of New York. In England and Continental Europe electro-thermic measures of destruction of malignant and at times other accessible lesions have been employed more extensively and with improved results to a larger degree than is generally known. To this newer and approved method of electro-thermic destruction, Dr. Wyeth has given the name "Endothermy." He defines it as surgical application of high frequency electrical currents and their conversion into heat within the tissues so that cellular destruction occurs. In this method, we have the use of mono-polar endothermy (electro-dessication) bipolar endothermy (electro-coagulation) (surgical diathermy) and more recently the endotherm knife (radio knife) each of which have certain refinements, advantages, and indications for use.

There is no specific form of treatment for hopelessly advanced cancer in any locality, but the end results in the surgical treatments of these cases of accessible cancer of the oral cavity and the range of operability are being improved and extended to a marked degree with this specialized form of heat destruction and excision. Endothermy occupies a worthy and preeminent rank in the destruction of neoplasms of the mouth and I urge its frequent use in accessible lesions in an attempt to effect an immediate removal or destruction of the primary growth in each case in so far as it is possible to do so. (Fig. 9.) This method or agency possesses the property of exact and prompt removal under direct control of the surgeon in a single operation and has the surgical refinements of destroying the infected and malignant cells in situ and at the same time seal the peripheral lymphatic channels and blood vessels, the pathways by which cancer cells tend to disseminate. There is little or no primary hemorrhage, it sterilizes the degenerating growth, thereby guarding against metastatic

FIG. 6.
Carcinoma of the left mid portion of tongue superimposed upon a specific glossitis of long standing. Four plus Wassermann despite vigorous anti-luetic therapy. Referred for bipolar endothermy. No demonstrable adenopathy. Bipolar endothermy for carcinoma of the tongue under nerve block anaesthesia. This picture was taken 8 weeks after operation, with tongue wound completely healed. Five months later fulminating glandular involvement appeared despite prophylactic x-ray therapy and patient died a month later from respiratory complications. There was no recurrence in the tongue at any time following the operation.

bacterial infection, reduces odor and fetor, there is more speed and facility of the operation to further safeguard against post-operative shock, and post-operative pain is much reduced. Its advantage over the cautery iron is that it does not carbonize and either superficial or deeper penetration are more accurately controlled. The surgical technique and end results with endothermy need only be observed and understood in order that they be fully appreciated. The same surgical, pathological and anatomical principles must necessarily be carefully understood as for any major surgical procedure.

The impressions and conclusions of various surgeons who have used endothermy is of importance to record. Dr. Geo. A. Wyeth says: "Our confidence in endothermy as a treatment for the removal of malignant lesions of the oral

FIG. 7.

Tubercular ulcerations on the left buccal surface at the angle of the mouth. Patient also has pulmonary tuberculosis, not active. Bipolar endothermy under local anaesthesia, in October, 1926. Wound healed in 4 weeks. Patient has not been observed since he left the hospital.

cavity and our belief that better results will be achieved in the treatment of all neoplasms when endothermy is employed in the beginning in all these cases to which it is applicable, are based upon the records made upon cases referred for treatment in many instances, after other surgical and physical measures, one or both, have failed. Endothermy should be given the preference in treating malignant lesions of the oral cavity. No other method offers the same protection against the dangers of recurrence and the threat of metastases." Childe of London in "Cancer and the Public" (1925) says: "In the present state of our knowledge and experience the treatment of cancer of the mouth with radium first in cases suitable for surgical removal is equivalent to deliberately forfeiting always their best chance and frequently their only chance of cure. He also states that x-ray and radium therapy have well-known and permanent places in the treatment of malignant lesions of the mouth and tongue but they have a most limited role in early and accessible localized lesions where prompt complete surgical destruction or excision is possible and the chances of cure are good."

In 1923, Davis Colley of London said: "I believe diathermy (bipolar endothermy) to be the most hopeful treatment in all cases of carcinoma in the mouth whether they be amenable to complete excision or not; and I have used this method entirely for the past 18 months with much better results than I have ever obtained with knife alone."

Claude Saberton wrote in the British Medical Journal in 1921: "We operate upon all diseases of the tongue and floor of the mouth by the diathermy method (bipolar endothermy) believing that any cases operable by ordinary methods are much better treated by diathermy (bipolar endothermy) and also that it is possible to remove successfully some growths otherwise inoperable."

Dr. Geo. W. Crile has said: "The most efficient method of destroying an early cancer of the tongue is electro-coagulation (bipolar endothermy) or cauterization with the actual cautery."

Dr. Howard Kelly refers to endothermy as the "new surgery" and recommends it as "a great addition to our technique, not only enabling us to do some things better, but greatly enlarging our field of beneficent activity."

Dr. Gordon B. New of the Mayo Clinic states that in malignant tumors of the antrum, since 1917, he has used the cautery and radium packs in their treatment and for the past several years surgical diathermy (bipolar endothermy) has almost entirely replaced the cautery with a result that operative deaths are eliminated, and more patients are cured than by previous methods of operation.

Norman Patterson of London has said: "No excision of a carcinomatous growth in the tongue, mouth or pharynx, however small that growth may be, should be carried out with the knife if diathermy (bipolar endothermy) is available."

Howard A. Kelly said: "Around every focus of malignancy there is an invisible presumptive path of extension. In this area of shadows, the surgeon makes his blunders, especially if he is operating on

the face, in his anxiety to save tissue and prevent deformity. Endothermy takes care of this and in using it one can safely do an erosion of a wider area without fear of disfiguring contractures. It is possible to pick out minute points and treat them alone as on the conjunctive."

Recently F. C. Wood has said: "My own attitude on the moot question of the treatment of neoplasms has been for years that all operable malignant tumors should be treated by the surgeon for the reason that up to the present time, no body of evidence has been brought forward to show that radiation in operable cancer is more effective or even as effective as good surgery."

RADIATION

Radiation in the form of radium and roentgen rays is also of value in the treatment of cancer of the buccal cavity. There are some who give it preeminence in the management of this group of cases. However, the consensus of opinion of a large number of men with large experiences and my own impressions prompt me to urge a direct surgical attack with endothermy on any primary accessible malignant oral lesion, whenever possible and employ radiation as an adjunct at the time of operation or subsequently in selected cases if necessary. Radium emanation seeds should be used for selected inoperable cases in which palliative results may be hoped for. Combined treatment in borderline cases should appeal to one as reasonable and distinctly advantageous, thereby incorporating the benefits of both endothermy, radium and x-ray. Radiation may be of benefit too, in early local recurrences where operation is contraindicated for any reason.

The surface applications of radium and radium needles have been replaced by a newer and a better method of implanting "seeds" of radium emanation (radons) into and around an oral lesion. Radon has the advantage of a sustained intensive action on the lesion over a definite period of time, but with a maximum intensity within the first 14 days after its introduction. One millicurie of radon has a total radiation of 132 millicurie hours in 30 days time after which it is inert, due to the fact that radon loses its activity at the rate of 15 per cent of itself each 24 hours. These "seeds" are distributed uniformly throughout the neoplasm and its border with a fine trocar needle on a basis of one millicurie per cubic centimeter of tissue. Fine tubules of glass, gold or platinum are used as containers. Where metal containers are used as a filter necrosis is reduced or avoided and larger amounts of emanation can be employed in a single center. When glass "seeds" are used one-half to one millicurie units are employed. Joseph Muir of New York has adopted a 0.3 mm. platinum seed container that is removable and limits the amount of radon employed in a single center to 2.5 millicuries.

Dr. Figi has recently reported the experience at the Mayo Clinic in the use of radium implants over a 3-year period in 150 cases of malignant tumors involving structures around the head and neck in which operation was contraindicated. The results

FIG. 8.

Epithelioma of the soft palate and left anterior pillar of 10 months' duration. Bipolar endothermy April, 1925, under local anaesthesia. Prophylactic x-ray treatment to cervical glands although no adenopathy demonstrable. November, 1925, solitary left cervical adenopathy. Prompt excision of the glands, including parotid group for metastatic carcinoma. Endotherm knife used throughout entire gland operation. Local anaesthesia. No evidence of recurrence January 1, 1927. Patient has some left occipital pain of indeterminate origin for the past 3 months, unless it be circulatory. Negative eye ground examination and stereoscopic x-ray examinations of tables of skull are negative for any evidence of metastases. Patient is 66 years of age. This picture was taken in September, 1926, showing a small defect about 1½ centimeters in diameter in the soft palate. No plastic operation was thought advisable or necessary at any time.

in some cases were very good although many lesions were extensive and classed as inoperable.

Radon possesses the refinement of placing the radio-active substance in immediate contact within the neoplasm and eliminates the violent reaction to the surrounding adjacent healthy structures. The dosage is exact and all its desired rays are utilized. Gross and minute lesions can be treated accurately and at one time. Trauma and pain are reduced to a minimum. In borderline operable cases or of indeterminate extent, radon inserted into the wound at the time of the operation is a valuable adjunct. Radon implants are contra-

indicated in close proximity to large vessels and to bone.

Many other workers have reported cases of oral cancer treated with radon with impressive results. A judicious plan of treatment combining the advantages of endothermy, of radium and of roentgen therapy in selected cases will often yield results that no one method can obtain.

THE LYMPH GLANDS

The treatment of the regional lymph glands is fully as important as that of the primary lesion itself. In fact, the complication of metastases is more difficult to eradicate than the accessible malignant disease at its source. Conclusions on this important question cannot be made in a dogmatic or an unqualified manner, nor can they be more than summed up in a general way. Each case is best decided upon individually, taking all the many pertinent and important facts and conditions into consideration. There are some recognized facts and conclusions, however, with which most experienced surgeons and radio-therapists will agree.

REGIONAL LYMPH GLANDS NOT PALPABLE OR CLINICALLY DOUBTFUL

Channing C. Simmons stated in a very recent and an excellent paper on "Cancer of the Mouth": "In the early cases, comparatively little reliance as to metastases can be placed on the presence or absence of palpable glands." Seventy-one per cent of Simmons' 318 primary cases presented clinical evidence of metastases when first seen. When glands are palpable, nearly one-half proved to be cancer and where no glands were palpable, 25 per cent showed histological evidence of cancer in a small series.

Judd's experience with carcinoma of the lip showed a 24 per cent incidence of glandular involvement in the operable cases. Bloodgood's reports show a 34 per cent incidence in the lip lesions. It is very probable that in smaller surgical centers and in our individual experiences the percentage of glandular involvement in oral cancers is greater. The frequency of metastases in lesions in other parts of the oral cavity is certainly higher since the lip is comparatively a more favorable site in which to effect a surgical cure, and the regional glands draining the lower lip are much more easily examined and detected than some of the deeper nodes. It is well known too that in the early stages of glandular involvement, there may be no adenopathy demonstrable, even in the submental and the submaxillary groups of glands. Furthermore we may have a palpable and demonstrable adenopathy that is singly inflammatory from secondary infection. In the absence of demonstrable adenopathy, conservative and x-ray or radium therapy to the cervical glands is frequently advised as a wise prophylactic measure. The procedure may be varied, however, and prompt early excision of the regional glands performed. If histological examination of the primary lesion at operation shows a virulent grade of malignancy that would render an indictment of probable glandular involvement the glands should be removed empirically. Under these circumstances, the surgeon is fully rewarded for his diligence in frequently finding early glandular involvement to

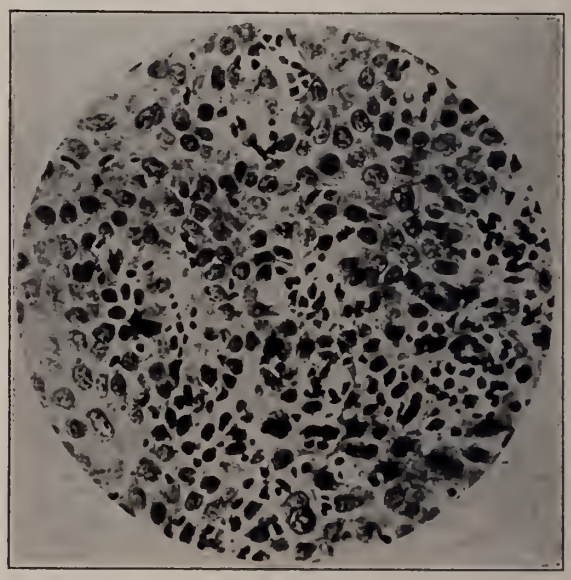

FIG. 9.
Epithelioma of the tongue in the left anterior lateral portion of 2 months' duration. Referred for endothermy. Operated on in February, 1924, with bipolar endothermy under local anaesthesia. No cervical adenopathy. Preoperative and post-operative prophylactic x-ray therapy to cervical glands. Prompt healing of the wound after operation. No recurrence when last seen in July, 1926.

his surprise, and equally so if he finds no evidence of metastases on histological examination of the glands. Post-operative cervical x-ray therapy is advisable, irregardless of the pathological findings in the operative glands.

REGIONAL ADENOPATHY OF INDETERMINATE PATHOLOGY

For the clinically demonstrable cervical adenopathy accompanying oral cancer in the early stages, a more positive position should be taken. There is in the present literature too much of a tendency to treat lightly the early cervical adenopathy and

consider it solely as an adenitis. This attitude is not safely in keeping with the facts and it is not consistent with our teaching and with our plea for early recognition of possible malignant foci and their prompt and complete excision or destruction. Tenderness in a gland region does not mean inflammation present and malignancy absent. Taking the large group of oral malignancies as they are seen clinically, with our present knowledge of oral and cervical glandular pathology, and until better methods are devised for the gross differential diagnosis of questionable glandular pathology, it is wise and duly conservative to presume that any cervical adenopathy, coincident with or subsequent to a primary malignant lesion is malignant until proven otherwise histologically. (Fig. 10.) A single exception may be the grade one carcinoma

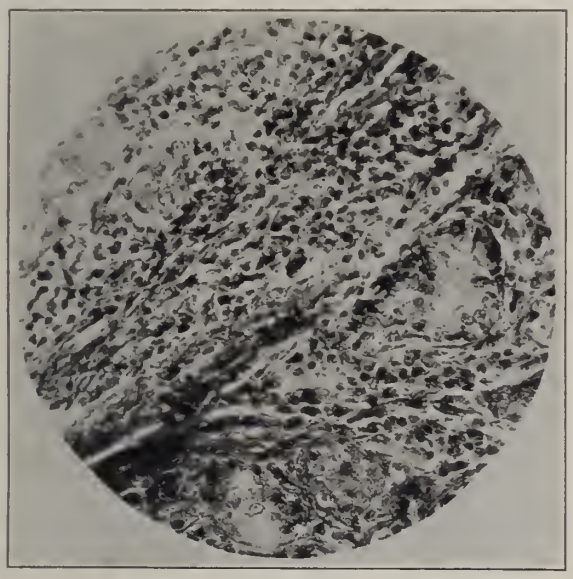

FIG. 10.

Extensive carcinoma of the lower lip with palpable submental glands. Patient 70 years of age. Duration of the disease, 10 months. Referred for operation with endothermy October, 1926. Wide excision of lip lesion and plastic closure of defect under local anaesthesia. One week later excision of submental glands for carcinoma and the submaxillary salivary group on the right side under local anaesthesia. Endotherm knife used exclusively throughout both operations.

of the lower lip and possibly the early papillary carcinomas of the tongue, and cheek which tend to metastasize late. The presence of simple or suppurative adenitis aggravates malignant cellular activity within it as well as to simulate a carcinomatous gland, and inflammation adds to the gravity when it complicates metastases in a group of glands. Suppuration actually tends to disseminate a malignant disease within the lymph glands if they be involved as well as to rob them of their protective power. The incidence of unnecessary early glandular excision is not commensurate with the gravity of possible extensive glandular involvement and dissemination that is inevitable from watchful waiting and masterful inactivity save for the value of x-ray therapy. The group excision of glands where indicated can be performed for the most part under local anesthesia with little or no hazard or disability. As has been indicated elsewhere, the endotherm knife should be used preferably in the operation as it seals lymphatic channels as it severs, leaving a clean dry field as it passes that enables one to get a dry wound with practically no drainage, and primary union with little or no cosmetic defects nor dangers of wound implants, refinements that no other agency of excision has to a similar degree. The emphasis placed on the danger of breaking a part of Nature's lymphatic defense in the occasional unnecessary excision of suspected adenopathy is probably more theoretical than real. I am reasonably certain that more necessary early glandular excisions have been unwarrantedly postponed as a result of this optimism and theory than the surgical results of later glandular attack have proven successful.

THE CLINICALLY INVOLVED GLANDS

What has been said about the surgical management of cervical adenopathy of doubtful or questionable malignancy applies more positively to the solitary groups of cervical glands that are malignant. Prompt wide excision of these malignant nodes should be carried out with the endotherm knife as soon as they are recognized, and irregardless of what x-ray therapy has or has not been given and then to be followed by more x-ray therapy. The pre-operative x-ray treatment of glands about to be excised is advisable. There is scarcely any who will not follow with thorough post-operative x-ray treatment, preferably at the hands of a specialized x-ray therapist. The whole problem of surgical attack on probable or known carcinomatous glands is dependent primarily on the probable results or chances of a cure of the primary lesion, the age and condition of the patient, the cellular virulence and the extent of gland involvement. To remove regional accessible glands in a case where success in treating the primary lesion is impossible or improbable is to invite criticism and to discredit surgery. And, finally, it can be safely stated that extensive gland dissections in late and widespread involvement that

defies and defeats chances of recovery is followed by an early and an unusually high percentage of recurrences and rapid dissemination by either incomplete solitary group excisions or bloc removals. One more point should be emphasized; Where glands appear later that were not present at the time of the destruction of the primary lesion, examine carefully the site of the primary lesion for possible recurrence.

RECURRENCES

Recurrences may be local or in regional or collateral glands or occasionally in remote locations. Simmons says: "Of the primary cases dying of recurrence of the disease, life is prolonged by treatment, but the patient lives longer following operative treatment than following radiation treatment." Careful and diligent follow-up examinations, even including microscopic examination of suspicious areas should be made. Secondary operations should be done in selected cases with endothermy, radium seed therapy in others, or a combination of both as adjuncts to the post-operative x-ray treatment.

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DISCUSSION

Dr. H. R. Foerster (Milwaukee): I wish to discuss Dr. McMahon's paper chiefly from the point of view of the radiologist. The theme of the paper has significance which warrants analysis. He treats of progress made by newer methods of treatment. There are some who will deny that progress has been made in the treatment of carcinoma of the oral cavity excepting in so far as progress has been made by education, by getting patients to the surgeon earlier. I believe, however, that the work done with the endotherm knife by the men quoted by Dr. McMahon, and by Dr. McMahon himself, is irrefutable proof of progress in the surgical treatment of malignancy. Some say that endothermy is not a new method of treatment, that it is merely another form of surgery, that it is merely a modified electro-cautery. It is a form of electro-cautery, but nevertheless it permits of surgical removal of malignancies which are not amenable to treatment with the scalpel or with the thermocautery.

It does away with the disadvantages of the necrosis and coagulation produced by heat with the thermocautery and it allows a finer dissection than is obtained by means of the old electro-cautery. Evidence of progress in the treatment of these conditions is indicated in itself by the changes in radiotherapy. X-ray has never proven curative in treatment of carcinoma of the mouth, but radium had quite a boom at one time and was employed in cases that were not amenable to the scalpel. Surface applications of radium gave place to treatment by imbedding radium needles, and that form of treatment has been replaced by the radium emanation. The chief objection to radium emanation has been that the very soft rays which are obtained by imbedding glass seeds produce extensive sloughing which favors secondary infection and which is very painful and which weakens the patient's resistance through the pain, through the prolonged period of disability, and that objection has been overcome by the use of gold seeds in which the soft rays are excluded by the gold film and the softer radiation is not in evidence. The reaction to the use of gold implants is very mild as contrasted to the violent reactions from the glass seeds.

Another advantage of radium emanation over radium needles and radium packs is that the action of the radium is maintained over a long period of time; instead of being applied for several hours it is applied for days, and in that way exerts a lethal or depressant action on malignant cells during various stages of their mitotic activity.

I believe that Dr. McMahon has indicated in his discussion the advantages of electro-cautery by endothermy over all previous methods of treatment, including treatment with radium, though I do think that excepting in very early cases that treatment by endothermy should be reinforced by the additional use of implants of radium emanation in the zone beyond the area of disease.

Another subject of importance that has been touched upon is the metastatic gland. That is the most difficult problem that the surgeon and the radiotherapist has to face. Removal of the primary lesion successfully does not in itself indicate likelihood of cure if there are metastatic glands, and the treatment of metastatic glands is one that has been the subject of much controversy. Some men advocate radical block dissection of the drainage areas, yet if that is done routinely in all cases it is done unnecessarily in a great many cases because only from twenty to forty per cent of such glands will show evidence of metastasis. What is probably an approved method of treatment of the glandular areas is x-ray treatment to the glandular areas in the clinical absence of evidences of malignancy, conservative dissection when there is slight evidence of metastatic involvement, preceded and followed by x-ray treatment, and radium emanation implanted in situ after removal of the glands.

Dr. McMahon is to be complimented on his very concise and thorough presentation of his subject and on his very modest claims for results obtained.

The X-Rays and Radium in the Fight Against Cancer*

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In the campaign against cancer, all possible resources must be utilized. Until the exact cause of cancer has been determined and a specific cure has been found, our aims in this fight must be:

1. To remove, in the individual patients the unhealthy conditions, which we have learned precede cancer and thus possibly prevent cancer;

2. To make an early diagnosis, while the disease is still local;

3. To treat the disease immediately, radically, and thoroughly.

The early diagnosis of cancer, so far as our present knowledge goes, is the most important factor in the treatment of the disease. It is only rarely that any method of treatment can be successful when the disease is far advanced and has spread to distant parts. With the medical knowledge now available, cancer should be recognized while it is still a local disease, with the exception of some of the cancers of the viscera. If the disease is recognized while it is still localized and if it is completely removed, a cure may be expected.

Early diagnosis depends upon two factors:

1. The public must learn to know the symptoms which suggest cancer. This can be accomplished by public lectures as recommended by the American Society for the Control of Cancer, but even more effectually by the physician in his daily work as he comes in contact with the patients and their families.

2. The physician must be thorough in his examinations and utilize every method of differentiation that is available. Periodic health examinations, if thoroughly done, will help in the early recognition of cancer. If all symptoms which suggest cancer are relieved, some cancers will be prevented and many cured in the early stages. It is self-evident that to accomplish these ideal results, every physician must be a keen student and thoroughly conscientious in his work.

The x-rays are an important factor in the early diagnosis of cancer of the oesophagus, the stomach, the colon, and the rectum. The x-rays are also most important in the diagnosis of tumors involving the bones, the chest, the liver, the pancreas, and the brain and spinal cord.

RADIATION THERAPY

The x-rays and radium are also of definite value in the treatment of cancer. The earlier, the more thoroughly, and the more skilfully the radiation is applied, the better will be the results. It is just as important with radiation, as with surgery to make an early and accurate diagnosis, to determine the total extent of the disease and then to surround the disease with the radiation sufficient to overcome it. So far as our present knowledge goes, the x-rays and radium only have an effect on the tissues which are actually penetrated by the rays. Therefore, so far as possible, all of the cancer tissue should be equally and thoroughly irradiated.

The x-rays and radium exert a somewhat selective effect on proliferating tissue cells and especially on tumor cells. Krönig and Friedrich[1] have shown by carefully conducted experiments that in like quantity the gamma rays from radium have about three times the biological effect of the most penetrating x-rays that are in practical use. This effect, of course, demands that a like quantity of radiation from the radium shall reach the diseased tissue. In the treatment of deep-seated disease, however, it is commonly easier to deliver three times as much radiation from the x-rays as from radium. When the gamma rays from radium can be used sufficiently to reach all parts of the disease, the results will be better.

Ewing[2] says, "In general, the tumors derived from embryonal cells and retaining embryonal characters, even when growing rapidly, are as a rule, particularly susceptible to radiation. Very cellular rapidly growing tumors of any type, even when derived from adult cells, are often very susceptible to radiation, although the rapid extension of such tumors renders the prognosis poor."

Strictly speaking, cancer is a microscopical disease; its extensions are microscopical and the curative changes can be studied microscopically. Yet from a practical clinical standpoint, we must deal with cancer today as a disease that can be seen and felt.

Knowing from scientific records the manner of

*Presented before the Radiological Society of North America, Wisconsin Day, Dec. 1, 1926, Milwaukee.

extension of the disease, we aim to surround it by total excision in its earliest stages, or to surround it by destructive radiation. Radiation can be more extensive than surgical excision, but generally speaking the combination of radiation and excision will accomplish the best results.

Pre-operative radiation in an operable case should be of advantage to devitalize the cancer cells and thus make them less likely to grow if transplanted during an operation. This devitalizing effect has been shown experimentally by Nogier, Jaubert de Beaujen, and Contamin[3] who found that the half of the tissue from an adenocarcinoma which had been irradiated and then innoculated into fifteen mice did not take while the other half of the tumor which had not been irradiated when innoculated into controls took in fourteen out of fifteen. The pre-operative radiation also has a favorable effect upon the surrounding tissue as has been shown in the experiments by Murphy[4] and his colleagues at the Rockefeller Institute, which demonstrated that irradiated tissue resists the innoculation of cancer tissue.

In operable cases in which pre-operative radiation is given, the operation should be done as soon as the constitutional effects of the radiation have passed. The operation can be done usually in from two days to two weeks after the beginning of the radiation, depending upon the location of the disease, and the amount of radiation that is needed.

Pre-operative radiation can be used also in inoperable cases in preparation for operations. In such cases the aim is to change the outlying disease to fibrous tissue, and then after two or three months to remove the remaining palpable tumor, which will commonly be found to still contain some cancer cells.

Post-operative radiation is now almost universally accepted as an advantage. It is based upon the theory that we are treating remnants of the cancer which cannot be seen nor felt, and therefore have not been removed. The common recurrence of the disease following operation, excepting in the very early cases, shows that it is commonly impossible to remove all of the cancer cells. We have all seen the permanent disappearance of palpable and visible recurrent cancer under the influence of radiation. We have a right, therefore, to assume that if the disease will disappear when it has grown long enough to be seen and felt that similar tissue would disappear in the same manner if treated while it is only of microscopical size. The value of post-operative treatment has also been shown by statistical studies, and will be referred to in connection with breast cancer.

Post-operative radiation should be given as soon after the operation as is practical which will usually be within from one to two weeks. Fractional doses seem to be preferable to massive doses, but the fractional doses should be carefully measured, and their cumulative value estimated. We should avoid atrophy, fibrosis, and telangiectasis.

From a practical standpoint in radiotherapy we must consider cancer as it affects different parts of the body. In every instance, the plan of treatment must be adapted to the individual case. Toward this end it would be an advantage if the family physician, the surgeon and the radiologist could confer and then decide upon the best treatment to be used upon each patient.

COMPARATIVE VALUES OF OTHER CLINICS AND METHODS (OPERABLE CASES)

		Alive 3 years		Alive 5 years	
		No Glands Per Cent	With Glands Per Cent	No Glands Per Cent	With Glands Per Cent
Greenough	Surgery	47	19		
Krönig	Surgery			100	39
Bloodgood	Surgery			70	20
Lee	Surgery				15
Finsterer	Surgery				4.3
Döderlein	Surgery			46	5
Döderlein	Surgery and radiation not completed			48	20
Döderlein	Surgery and radiation totally completed			80	36
Wintz	Surgery and radiation both groups 77 %			48	
Schmitz	Surgery and radiation			64	42
Pfahler & Widman	Surgery and radiation			68	46

CANCER OF THE SKIN

If treated while the cancer involves only the skin, practically all should recover, either with radiation alone, or with radiation following electro-coagulation. Cancer about the eye-lids, and in any location where the greatest possible conservation of tissue is necessary, are best treated by radium. When a soft scar is not objectionable as in most parts of the body it is my practice to destroy the lesion at once by means of electro-coagulation, curette the base and then follow by radiation. This gives the quickest and entirely satisfactory results.

CANCER OF THE BREAST

When cancer of the breast can be diagnosed while it is strictly localized and therefore can be completely removed, we believe that immediate excision is the proper treatment. Unfortunately, only a small percentage are operated upon in this early stage. In a recent report from London (Leeds) by Dr. Janet Lane-Clayton only 17 per cent were in this early operable stage, or only about one in six. Therefore, in about five out of six cases we must realize that the disease has spread and in these cases, radiation and operation can be combined to advantage. The advantages of combining radiation have been shown, especially by the statistics of Döderlein,[5] Wintz,[6] Schmitz,[7] and by an analysis of *over* 800 breast cases studied by Widman and myself.

It will be seen from the above chart that if patients are thoroughly and skilfully operated upon while the disease is *still strictly localized,* that surgeons have obtained 47 to 100 per cent cures; but when the disease has spread to the *glands of the axilla* various authors report only from 4.3 to 39 per cent recovery from operation alone, the general average being about 20 per cent or one in five.

If, however, the operation is combined with radiation the five year cures are increased as reported by various authors to from 36 to 46 per cent or just about double the value of operation alone. The patients with *inoperable primary,* or with *recurrent cancers* of the breast can have their lives prolonged, made more comfortable, and some can be cured.

CANCER OF THE LIP

If every sore or crust that forms on the lip is treated immediately and thoroughly, cancer of the lip can generally be prevented. If cancer is treated at the beginning by thorough electro-coagulation and associated thorough radiation over the local area and over the adjacent lymphatics[9-10] we have found that it can be cured in about 90 per cent of the cases, providing it is treated before there are palpable lymph nodes. Shreiner[11] has found that even in cases that have an involvement of the lymphatics, but from the standpoint of surgery are considered in an inoperable stage, can be healed in at least 34 per cent of the cases.

In the Radium Home in Stockholm, Sweden, which is under the direction of Forsell, primary cancer of the lip has been cured in 77 per cent of the 133 cases treated[12].

CANCER OF THE TONGUE AND MOUTH

These cancers of the tongue and mouth are practically all of the squamous cell type. They spread rapidly to the surrounding tissue and within six weeks often become inoperable or even incurable. Therefore, any sore about the tongue or mouth that does not begin to heal within two weeks should

TABLE I

CASES TREATED BY RADIUM THERAPY
1918 to 1921 Inclusive
(Service of Dr. Harold Bailey)

		Total	Alive Jan. 1, 1925	Alive, Per Cent
Cervix—				
Early	9%	35	14	40
Borderline	14%	52	14	27
Advanced	77%	288	25	8.6
Total cervix		375	53	14
Recurrent cervix		139	28	20
Postoperative irradiation		25	16	64

American Journal of Roentgenology—December, 1925, Vol. 14, No. 6, pp. 542-546.

TABLE II

CASES TREATED BY COMBINED RADIUM AND ROENTGEN THERAPY
1922 to 1924 Inclusive
(Service of Dr. William P. Healy)

		Total	Alive	Alive, Per Cent
Cervix—				
Early	12%	44	41	93
Borderline	16%	57	42	73.6
Advanced	72%	252	113	44.8
Total cervix		353	196	61
Recurrent cervix		71	41	57.7
Postoperative irradiation		5	5	100

be regarded as malignant until proven otherwise, and should be treated accordingly.

TABLE III

PER CENT OF FIVE YEAR CURES FOR ALL CASES TREATED

Clark and Keene	19.2
Von Seuffert	10.0
L. Seitz	20.9
Gustav C. J. Scholten	13.8
H. Döderlein	13.2
Robert B. Greenough	11.0
Henry Schmitz	14.5
H. V. James Heyman	20.29
C. Regaud	20.00
H. A. Kelly	20.00
Parache	19.75
Average	17.05

Martin & Rogers, Proceedings American Roentgen Ray Society, September, 1925.

The chief etiological factors are chronic irritation as from tobacco, sharp edged teeth, badly fitting plates, repeated applications of chemicals, etc., and syphilis (positive Wassermann in 14 to 40 per cent in different reported series). Therefore, when a positive Wassermann test is found, the diagnosis of cancer is not excluded, and, if anti-syphilitic treatment gives no definite improvement within two weeks, cancer is likely present. Cancer of the tongue and floor of the mouth, when treated thoroughly and skilfully by radiation or at times associated with electro-coagulation should be cured in at least 25 per cent of the cases. This applies to the general average as they come, and my recent observations lead me to expect more. If, however, all lesions of the tongue and mouth are treated thoroughly and skilfully at the beginning cancer should be prevented or cured in nearly all cases.

Regaud[13] in the Radium Institute of Paris records 24 per cent of cures of cancer of the tongue from one to five years, by means of radiation, counting all the cases treated, and *46 per cent of the cases that can be classed as operable.* Forsell[12] at the Radium Home in Stockholm obtained *38 per cent of cures in the general cases* of cancer of the tongue.

Cancer of the gums, cheeks, tonsils, and pharynx seem to me to be more responsible to radiation treatment than those which involve the tongue and floor of the mouth. Radium, if used in sufficient quantity, is much superior to the x-rays in the treatment of intra-oral cancer.

CANCER OF THE UTERUS

Radiation has been found especially useful in the treatment of cancer of the cervix uteri. Various authors report from 40 to 80 per cent five year cures in the cases in which the disease is still confined to the uterus and classed as operable, and 25 to 40 per cent when the clearly operable and borderline cases are classed together. The earlier a case is treated and the more thoroughly and skilfully the radiation is applied the better will be the results.

CURES IN THE OPERABLE AND BORDERLINE CASES OF CARCINOMA OF THE CERVIX

Hayman[14] found five year cures in this more

TABLE NO. IV

CARCINOMA OF UTERUS

Seuffert, 1923, P. 482—Cures of 5 years or more. Döderlein's Clinic, Munich.

I Group Therapy	Total Cases Treated	Still Operable Group I	5 year cures in Group I	II Group Therapy	Total Cases Treated in Clinic	Borderline Cases—Group II	5 year Cures Group II
Operation	265	42%—110	51—46%	Operation	265	22%—57	3— 5%
Radiation	500	15%—77	87—48%	Radiation	500	19%—90	18—20%
Completed Radiation Treatment	77	55%— 43	35—80%	Completed Radiation Treatment	90	56%—50	18—36%

III Group Therapy	Total Cases Treated in Clinic	Positively Inoperable Cases—Group III	5 year cures in Group III	IV Group Therapy	Total Cases Treated in Clinic	Hopeless Cases—Group IV	5 year cures Group IV
Operation	265	34%— 92	0— 0%	Operation	265	2%— 6	0— 0 %
Radiation	500	43%—214	13— 6%	Radiation	500	23%—119	1— 0.8%
Completed Radiation Treatment	214	57%—121	13—11%	Completed Radiation Treatment	119	17%— 20	1— 5 %

TABLE NO. V
CARCINOMA OF THE CERVIX
From Döderlein's Clinic (Munich)
Seuffert 484—Absolute Values of Operation, or Radiation in Carcinoma of the Uterus.

Time Period	1908-1912				1913-1916					
THERAPY	Operable Cases I Group	Borderline Cases III Group	I-II Groups Operability	"Relative" Curative Values	Inoperable Cases Group III	Hopeless Cases IV Group	Total of All Cases All Groups	Well at least 5 years	"Absolute" Curative Values
Total No. Treated.....	42%—110	22%—57	63%—167	of 167 cases	34%—92	2%— 6	167+92+6=265		
Cured by Operation.....	51—46%	3— 5%		51+3=54—32%	0— 0%	0— 0%		54+0+0=54	265 / 54 — 20%
Operative Value of Cases Treated during this period	46%—35	5%— 5		35+5=40—24%	0%— 0	0%— 0		40+0+0=40	500 / 40 — 8%
Of All Cases in the Clinic	15%—77	19%—90	34%—167	of 167	43%—214	22%—119	167+214+119=500	55+13+1=69	
Cured by Radiation.....	37—48%	18—20%		37+18=55—34%	13— 6%	1— 0.8%			500 / 69 — 14%
Total of Cases Completing Radiation Treatment	55%—43	56%—50	55.5%— 93		57%—121	17%—20			
Completed Treatment Cured	35—80%	18—36%		35+18=53—58%	13—11%	1— 0.8%	93+121+20=234	53+13+1=67	234 / 67 — 29%

select class of cases treated in the Radium Home in Stockholm to be 40 per cent, while the general report[12] from this home shows 32 per cent to be free from symptoms during a period of from one to five years when all the cases are considered. Mattick[15] reports 80 per cent cures in group 1, 40.7 per cent in group 2 and 10.8 per cent of all cases (368) as they come, treated before 1924.

Healy[16] reports from the service of Dr. Bailey in cases treated 1918 to 1921 inclusive and from his own service in cases from 1922 to 1924 inclusive as shown in Tables I and II.

Healey concludes:

1. From a study of our own statistics it would seem reasonable to assume that a diagnosis of cancer of the uterine cervix is an indication for radium therapy.

2. Operation is justifiable only when serious contraindications to radiation therapy are present.

In estimating the value of radiation treatment of cancer of the cervix it must be remembered that only about 12 to 35 per cent of all the cases can be considered for operation because the others are too far advanced. Therefore, operation statistics only deal with a small proportion of selected cases while radiation is used in all types of cases.

The total or average value of radiation when all types of cases are considered is shown in Table III prepared by Martin and Rogers.[16]

The advantage of early radiation treatment (48 to 80 per cent cures) compared with late treatment (6 to 0.8 per cent cures) are best shown by the statistics prepared by Seuffert, from the Döderlein clinic.

These statistics in Tables IV and V were prepared from cases studied in a general gynecological clinic. The same rules were applied in classifications for the radiation cases as for the operative cases. The group of cases making up the operation statistics were treated during the years from 1908 to 1912, while those used for the radiation statistics were treated from 1913 to 1916. The final classification shows the cures that might have been expected if these last 500 had been operated upon as compared with the actual cures obtained by radiation. Taking the operable and borderline cases together when treated by operation 24 per cent could have been expected to be cured by operation in this group of cases, while 34 per cent were actually cured by radiation. These statistics show that while the patients who came early and carried through their treatment thoroughly 80 per cent

were cured, while only 14 per cent of the general average were cured because most came late, and many did not finish their treatment.

Time will not permit a review of cancer of all parts of the body, but we may conclude as we began, *with our present knowledge, our hope lies in the early diagnosis of cancer and thorough radical treatment from the beginning.*

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Parkinsonism

BY JAMES E. McLOONE, M.D.
La Crosse

The diagnosis of "Flu" continues and we do have epidemics of hiccough, as occurred in Canada in 1925. Therefore a discussion of these conditions may not be amiss. Lethargic encephalitis and its sequelae continues also to prevail and is more frequently met with in general practice. Thus it becomes necessary for the practitioner to be on his guard against and recognize this disease. Particularly so because the initial mortality reaches the neighborhood of 35 per cent, and of these, 70 per cent which recover may have or develop residua.

Grossly and microscopically Hohman,[1] Goodhart[2] and Cottrell, Scholtz,[3] and others have shown destructive processes to be present in the ganglion cells of the locus niger, corpus striatum, thalamus and globus pallidus, collectively and in turn. Similar findings, even to hemorrhagic encephalitis, were found on bicopsy, by our and foreign investigators of those dying of influenza. This fact may perhaps explain why with every "flu" outbreak there are a few cases, at least, of frank lethargic encephalitis, as is reported by Kaiser and Peterson[4]. That lethargic encephalitis is a chronic process, a progressive disease, has been emphasized in the reports of Hohman, Freeman and Evans[5], and Meggendorfer[6]. Being such may possibly explain, to a degree, the spread of this disease, particularly by the post-encephalitic Parkinsonian individual. Guillian[7] reports such a contact, who later developed a typical acute encephalitis, and Freeman[8] reports from the literature seven such cases. It is partly because of this possibility of infection and as a possible aid in diagnosis of this particular sequel, I report a Parkinsonism and review the general symptoms.

CASE REPORT

Mr. L., aged 31, entered the hospital Sept. 5, 1926, complaining of lethargy and marked drooling from the mouth. In Feb., 1924, he suffered a gastro-intestinal upset, followed by a "flu." He remained in bed for several days during which time he was very restless and unable to sleep. About two weeks following onset, he became drowsy and although he did his farm work it was with effort. Frequently he came into the house and fell asleep in the chair or while eating his meals. In Sept., 1925, he finally lost all interest in everything around home or farm. This continued until the spring of 1926, when his stupidity and inertia forced the family to move to town. About March, 1926, he developed marked drooling, his facial expression became fixed, he became progressively weaker, and his movements stiff and jerky. Examination on entrance revealed the following classical symptoms of Parkinsonism:

1. Tremor of more or less degree.
2. Walks with a hesitating step, body weight forward and stride short; movements slow and jerky.
3. Sialorrhea, usually marked; saliva often running freely from the mouth.
4. Diminished muscular power.
5. Individual falls asleep unless kept forcefully aroused.
6. Involvement of cranial nerves.
7. Deep and superficial reflexes usually exaggerated.
8. Psychic process dulled—loss of interest in events, difficulty in retaining interest.
9. Speech slow and without inflection.
10. Postural rigidity, catatonic fixations, elbows flexed, masked face, staring expression, giving the individual a stupid expression.

This sequelae, being no respector of age or sex, is invariably progressive and in a period of months or years confines the individual to his bed. He dies of starvation, being unable to swallow, or some intercurrent infection. The treatment, therefore, must be primarily symptomatic. Hohman[9] and Erb used hyoscine hydrobromide in twenty-four decimilligram doses to control the tremor and with fair success. Henner[10] used sodium cocodylate in divided doses with only fair results. The individual does have periods of well being which may explain the partial success in the cases treated. Rosinow[11] reports some success with his serum, particularly in the acute encephalitic stage. In our case we used large doses of potassium iodide, 30 gr. three times daily, along with 3 gr. hypodermic doses of sod. cocodylate, twice daily. The individual's general condition, after a week's treatment, improved. He no longer fell asleep, he visited relatives in town during his stay in the hospital, and twice took in a moving picture. The sialorrhea stopped completely. He was discharged from the hospital on Sept. 23rd in this improved condition, taking the cocodylate by mouth, and the K. I., 10 M tid. On Oct. 15th he was again seen because the drooling returned. He was advised to increase the K.I. again to 30 M tid. and again in five or six days the complaint ceased. He then stopped all medication. To date this sialorrhea has not returned, but the other general symptoms persist and are becoming more pronounced.

We continue to speculate but do not accomplish, diagnose but not cure.

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TREATMENT OF LARYNGEAL TUBERCULOSIS IN SANATORIUM

Parfitt says that in the sanatorium, laryngeal tuberculosis has not proved fatal in cases which otherwise had a favorable prognosis. It has been the least dangerous complication of pulmonary tuberculosis and the one most amenable to treatment. It has often been arrested or cured before the patient had recovered from the pulmonary disease. Even in patients entering with advanced laryngeal lesions and bad prognosis, relative comfort can frequently be given by active measures.—J. A. M. A., Dec. 18, 1926.

PREVENTIVE MEDICINE

W. D. STOVALL, M. D., Editor

Investigation on the Dick Reaction in Scarlet Fever

BY ROBERT L. COWLES, M.D., AND LOUIS MILSON, M.D.
Green Bay

We were prompted to undertake this work on the Dick Reaction in Scarlet Fever for experimental purposes and as a matter of necessity in attempting to combat an onsetting epidemic of scarlet fever among some 45 infants and 37 adults at our infants' home.

On October 11th, 1925, one of our infants (two years of age) became acutely ill. The condition set in with a temperature of 103-104° and was followed in 24 hours by a purpuric scarlatini form eruption. The eruption was first noticed on the neck and upper part of the chest and later spread to abdomen and limbs. The tonsils and pharynx were swollen and congested and the tip of the tongue showed characteristic strawberry appearance. A diagnosis of scarlet fever was made and the infant was immediately isolated and general treatment instituted.

About 13 days following the beginning of illness of the first infant, another infant became acutely ill. He showed all the characteristics of a typical case of scarlet fever and was accordingly isolated. This was followed by another case of scarlet in a third infant five days later.

In an attempt to stop the spread of the infection we then began the work of immunization.

Dick tests were made on a total of 82 cases divided into three groups. The first group consisted of 28 cases of ages varying from infancy to that of adult age. The test injections were given with a .5 cubic centimeter record syringe graduated in tenths of cubic centimeter with a Luer tip and a ½ inch 26 gauge Summit needle. The syringe and needle were sterilized by boiling for at least 20 minutes. The left arm was cleansed with soap and water and an exact dose of 0.1 cubic centimeter of the skin test solution was injected intradermally on the flexor surface of the forearm at the junction of lower and middle thirds over an area free from blood vessels. Readings were then made on the tests at intervals varying from 6 to 44 hours, stress being laid on the 24-hour observations. The initial wheal from the intracutaneous injection disappeared in a few minutes. The erythema gradually increased, reaching its maximum intensity in 22 to 25 hours. It then began to fade away and in 48 hours the area of injection had lost its swelling and faded to a faint yellow. In making observations an area of pigmentation less than one centimeter in diameter was considered negative. The positive area of pigmentation varied from a faint pink, bright red, faint red, and intense red to a faded red. In some of the cases a scarlatinal rash appeared at the area of inoculation. Reactions that appeared and faded within 24 hours were considered as negative.

In the first group of cases we got 19 positive Dick reactions in 28 cases or an average of 66 per cent. Immunizing doses of scarlet fever toxin were then given to all positive cases. The syringe and needle were sterilized by boiling and the skin was cleansed at the point of injection by the use of alcohol. The injections were given intramuscularly in the Deltoid muscle at five-day intervals. Each injection consisted of one cubic centimeter of concentrated serum. The first injection was of a concentration sufficient to neutralize 500 skin test doses. This concentration was small enough to avoid serum reactions and yet sufficiently large to stimulate the production of antitoxin so that a larger dose may be given in the second injection. The second injection given after a five-day interval consisted of 1,000 skin test doses of scarlet fever toxin and was followed in five days by a third injection of 5,000 skin test doses.

About two weeks after the last injection the intracutaneous tests were repeated to determine the degree of developed immunity to scarlet fever. Readings were made on this test in 24 hours. We got 9 positive Dick tests or an average of 32.1 per cent positive tests. A fourth injection of 5,000 skin test doses was then given to cases whose immunity was not complete. About two weeks after this injection immunity was again checked by the

Dick test. This time we got three positive tests or an average of 10.7 per cent positive tests.

SECOND GROUP

The second group consisted of 39 cases of about the same ages as the first group. These were similarly tested by the injection of 0.1 cubic centimeter of scarlet fever toxin. Observations were made after 24 hours to determine the degree of immunity. In this group there were 19 positive tests out of 39 cases or an average of 48.7 per cent positives. Immunizing injections were then given to all cases showing susceptibility to scarlet fever. The method of procedure and the concentration of the toxin were similar to that of the first group. Three injections were given at 5 day intervals. About two weeks following the last injection, tests were again made to determine the degree of developed immunity. We obtained 8 positive tests or an average of 20.5 per cent positive reactions. A fourth injection of 5,000 skin test doses of scarlet fever toxin was then given to cases still showing susceptibility to scarlet fever. After two weeks immunity was again checked by another intracutaneous test. We now obtained 2 positive skin reactions or an average of 5.1 per cent positives.

Reaction following immunization was apparent to some extent in all cases. It varied from slight reddening at the area of inoculation to marked constitutional symptoms in others. Most all of our infants ran a temperature of 101-102° the 24 hours following the first injection; several cases (all infants) showed more marked reactions. These were transient, passing away in 24 hours or less and consisted of a scarlatinal rash, chills and a temperature of 104-105°. One of our infants showed slight desquamation several days following the injections.

THIRD GROUP

The third group consisted of young females in various stages of pregnancy. The degree of immunity to scarlet fever was similarly determined by the intracutaneous Dick tests. In this group we obtained 7 positive Dick reactions or 46.6 per cent positive reactions.

Immunization of this group was not considered advisable due to their pregnant condition.

SUMMARY AND CONCLUSIONS

Total number of cases tested, 82.

Total number of cases positive, 45 or 54.8 per cent.

Positive cases after third injection, 17 or 25.3 per cent of 67 counting the first two groups.

Positive cases after fourth injection, 5 or 7.4 per cent.

Total number of cases immunized, 33.

Note: The percentage of immunized cases was 87 per cent of the number of cases on whom immunization was attempted.

After the immunization work was completed the three infants who had scarlet fever were put back

TABULATED DATA

DATA ON THE FIRST GROUP

Number	Age	History of Scarlet	Test #1	Date of Injection #1	Date of Injection #2	Date of Injection #3	2nd Test	4th Injection	3rd Test
1	19m.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Pos.	Nov. 27th	Neg.
2	20m.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Neg.	.....	.....
3	15m.	No	Neg.	.....	.....	.....	.....	.....	.....
4	10m.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Neg.	.....	.....
5	10m.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Pos.	Nov. 27th	Pos.
6	18m.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Neg.	.....	.....
7	14m.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Pos.	Nov. 27th	Neg.
8	14m.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Pos.	Nov. 27th	Neg.
9	9m.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Pos.	Nov. 27th	Neg.
10	8m.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Neg.	.....	.....
11	4m.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Neg.	.....	.....
12	7m.	No	Neg.	.....	.....	.....	.....	.....	.....
13	1m.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Pos.	Nov. 27th	Neg.
14	13m.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Pos.	Nov. 27th	Pos.
15	13m.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Neg.	.....	.....
16	13m.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Neg.	Nov. 27th	Pos.
17	42 yrs.	Yes	Neg.	.....	.....	.....	.....	.....	.....
18	24 yrs.	Yes	Neg.	.....	.....	.....	.....	.....	.....
19	19 yrs.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Neg.	.....	.....
20	21 yrs.	Yes	Neg.	.....	.....	.....	.....	.....	.....
21	16 yrs.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Neg.	.....	.....
22	18 yrs.	Yes	Neg.	.....	.....	.....	.....	.....	.....
23	21 yrs.	Yes	Neg.	Oct. 30th	Nov. 5th	Nov. 10th	Neg.	.....	.....
24	16 yrs.	No	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Neg.	.....	.....
25	19 yrs.	Yes	Pos.	Oct. 30th	Nov. 5th	Nov. 10th	Pos.	Nov. 27th	Neg.
26	30m.	No	Neg.	.....	.....	.....	.....	.....	.....
27	27m.	No	Pos.	.....	.....	.....	.....	.....	.....
28	25m.	No	Neg.	.....	.....	.....	.....	.....	.....

in the ward. At this time desquamation was complete and there were no infectious discharges present.

Since the completion of our immunization work we had two cases of scarlet fever in two adults (one in December and one in April) on whom the Dick tests were not made. But we have had no cases of scarlet fever among our immunized infants for almost a year.

CONCLUSION

1. Positive Dick tests were obtained in 54.8 per cent of the total number of cases tested.

2. Positive Dick tests were obtained in 64.3 per cent of the cases that did not give any history of scarlet fever.

3. In tests on adults we obtained 50 per cent positive Dick tests.

4. In tests on infants of ages up to two years we obtained 76.7 per cent positive Dick tests.

5. There was evidently a higher percentage of positive tests among infants over 6 months of age than among adults.

6. In infants up to 6 months of age we obtained 50 per cent positive Dick tests, namely 8 out of 16 cases.

7. In tests on pregnant females we obtained 46.6 per cent positive Dick tests.

8. In the first group, the 3 cases who had scarlet fever before gave either negative or doubtful positive reactions.

9. Persons formerly ill with scarlet fever may sometimes give positive reactions.

10. Preventive immunization must be carried to the point of a negative skin test.

11. The skin test has a specific relation to immunity in scarlet fever.

12. Immunity can be acquired by the injection of scarlet fever toxin in properly graduated concentrations.

13. The immunity in our cases was acquired in about 3 or 4 weeks and has so far lasted 12 months.

14. Our results would seem to show the practical value of scarlet fever toxin used for immunization of those found to be susceptible to scarlet fever.

DATA ON THE THIRD GROUP

Number	Age	History of Scarlet	Test #1
1	16 yrs.	Yes	Neg.
2	17 yrs.	No	Pos.
3	17 yrs.	No	Pos.
4	25 yrs.	Yes	Pos.
5	18 yrs.	No	Pos.
6	19 yrs.	No	Neg.
7	20 yrs.	No	Pos.
8	19 yrs.	Yes	Neg.
9	16 yrs.	Yes	Pos.
10	22 yrs.	Yes	Neg.
11	16 yrs.	No	Pos.
12	17 yrs.	No	Pos.
13	16 yrs.	No	Neg.
14	25 yrs.	No	Neg.
15	17 yrs.	No	Neg.

DATA ON THE SECOND GROUP

Number	Age	History of Scarlet	Test #1	Date of Injection #1	Date of Injection #2	Date of Injection #3	2nd Test	4th Injection	3rd Test
1	20 yrs.	No	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
2	22 yrs.	No	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
3	19 yrs.	No	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
4	27 yrs.	No	Neg.	.....	.....	.....	.....	.....	.....
5	20 yrs.	No	Pos.	.....	.....	.....	.....	.....	.....
6	18 yrs.	No	Neg.	.....	.....	.....	.....	.....	.....
7	36 yrs.	No	Neg.	.....	.....	.....	.....	.....	.....
8	16 yrs.	No	Pos.	.....	.....	.....	Neg.	.....	.....
9	20 yrs.	Yes	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
10	16 yrs.	Yes	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
11	19 yrs.	Yes	Neg.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
12	19 yrs.	Yes	Neg.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
13	20 yrs.	No	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Pos.	Dec. 3rd	.....
14	20 yrs.	No	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
15	8m.	No	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
16	24 yrs.	Yes	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
17	3m.	No	Neg.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
18	5m.	No	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
19	3m.	No	Neg.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
20	3m.	No	Neg.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
21	2m.	No	Neg.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
22	4m.	No	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Pos.	Dec. 3rd	Pos.
23	4½m.	No	Neg.	Nov. 5th	Nov. 10th	Nov. 16th	Pos.	.....	.....
24	1½m.	No	Neg.	.....	.....	.....	.....	.....	.....
25	1½m.	No	Pos.	.....	.....	.....	.....	.....	Neg.
26	22 days	No	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Pos.	Dec. 3rd	Neg.
27	2m.	No	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Pos.	.....	.....
28	11m.	No	Neg.	Nov. 5th	Nov. 10th	Nov. 16th	Pos.	.....	.....
29	8m.	.....	.....	.....	.....	.....	.....	.....	.....
30	8m.	.....	.....	.....	.....	.....	.....	.....	.....
31	9m.	.....	.....	.....	.....	.....	.....	.....	.....
32	7m.	No	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
33	6m.	No	Neg.	.....	.....	.....	.....	.....	.....
34	6m.	No	Neg.	.....	.....	.....	.....	.....	.....
35	9m.	No	Neg.	.....	.....	.....	.....	.....	.....
36	8m.	No	Pos.	Nov. 5th	Nov. 10th	Nov. 16th	Neg.	.....	.....
37	7m.	No	Neg.	.....	.....	.....	.....	.....	.....
38	4m.	No	Neg.	.....	.....	.....	.....	.....	.....
39	3m.	No	Neg.	.....	.....	.....	.....	.....	.....

THE JOURNAL CLINIC

Diagnostic Problem

BY LOUIS M. WARFIELD, M.D.
Milwaukee

At the request of the Editorial Board, Dr. Warfield resumes with this issue his monthly discussion of cases interesting from a diagnostic standpoint.

A salesman, 53 years old, came to the Milwaukee County Dispensary for the first time on Jan. 19, 1924, complaining of cough, some pain in the chest and head, dizzy spells and itching of face and head. At times there is annoying secretion from his eyes and nose. He had had no serious febrile illnesses. In 1911 he was said to have had ulcer of the stomach which was cured. His appetite was good, bowels regular, urination normal. Physical examination at that time revealed no abnormalities. His weight had gradually decreased during several years from 200 to 163 pounds. Urinalysis was normal. Special examination of the throat and nasal sinuses revealed submerged infected tonsils and the nose showed evidence of old operation on the right middle turbinate bone. An x-ray (frontal) showed that the right antrum was blurred. This was irrigated and operation advised.

He was not seen again until Dec. 6, 1926, when he was referred from the Milwaukee County Hospital for general examination. He had been there the latter part of October for two days and was dismissed with a diagnosis of myocardial degeneration. He gave us the following history: About August 1st he was seized during the night with a terrific pain over the heart, the skin was cold and clammy, he was restless and short of breath. A doctor was called who gave him morphine and digitalis. The heart was beating so fast that it was difficult to count it, it was irregular and the pulse at times was barely perceptible. In spite of the morphine the pain lasted off and on for at least two days. Since that time he has lost weight, the least exertion makes him puff. He has had no swelling of the feet. He has been unable to do any work.

On physical examination he was a tall, thin man who evidently had lost weight and he looked ill. There was a peculiar pallor to his skin, although the mucous membranes were of good color. He was dyspneic on the least exertion. The chest was well formed, the bony framework prominent. Expansion was equal but shallow. There were a few mucous rales at the bases of both lungs. Elsewhere the lungs revealed no striking changes. The apex beat of the heart was seen in the 4th and 5th interspaces, a diffuse impulse, 13 cm. from the mid-sternal line. The rate was regular, 120 beats to the minute, with occasional extra systoles. There was a short systolic murmur at the apex transmitted only a few centimeters, and a harsh systolic murmur over the tricuspid area. The pulmonary second sound was accented, the aortic clear. The liver was slightly enlarged, the abdomen otherwise was negative. There was no edema of the ankles. The reflexes were present. Urinalysis was normal. The Wassermann reaction was negative. An electro-cardiogram showed large QRS complexes, no evidence of notching or widening of the bases of the complexes, an occasional left ventricular premature beat, and auricular flutter with a rate of 360 to the minute.

The diagnosis and discussion will appear in the Journal next month.

Erosive Balanitis; Case Report

BY H. E. KASTEN, M.D.
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Beloit

The intravenous administration of antimony and potassium tartrate and more recently sodium antimony thioglycollate and antimony thioglycollamide have given uniformly good results in granuloma inguinale. During the last few months several cases have been reported in the literature

showing the effectiveness of the intravenous administration of antimony and its several salts in certain resistant genital ulcers other than granuloma inguinale.

Dr. Young in Young's Urology presents a group of stubbornly resistant ulcers of the corona which he calls intractable ulcers of the penis. Other authors call them resistant erosive balanitis. The lesions in this group are particularly resistant to the usual forms of therapy and frequently go on to rather extensive destruction of the penis. Bacterial examinations are undeterminate as to the exact underlying etiology while biopsies show a chronic infectious process of a non-specific character.

The treatment usually exhausts the resourcefulness of the attending physician, and in time the morale of the patient. Antiseptics, irrigations, salves, powders and even cautery fail to stop the disease. The lesions grow larger and deeper and false urinary passages have been caused by erosion into the urethra.

Drs. Kingsbury and Peck have reported three cases, all of which were cured by antimony and potassium tartrate and the following case is typical of this group:

A white male, aged 53, presented himself for treatment, stating that two weeks previous he had noticed a gradual increasing soreness and discharge from a rather long foreskin. He then applied for treatment and it was found that he had three rather shallow ulcers in the sulcus posterior to the corona. These were treated with irrigations, calomel powders, iodoform, and hydrogen peroxide without the least effect. At the time of his admission to the Clinic, the foreskin was extremely edematous and exuding foul smelling grayish green pus. With considerable difficulty the foreskin could be retracted and it was found that the ulcers had become confluent and had eroded down to the urethra. The patient was put into the hospital and a dorsal slit done. The Wassermann and dark field were negative, bacterial examination was negative for Ducrey's bacillus. There was slight tenderness but no enlargement of neighboring lymph glands. Constitutional symptoms were negative except slight fever. Marked local pain was a constant feature.

Irrigations and antiseptic dressings were tried for a short time, but no improvement could be noticed. They were attended by excruciating pain, so it was decided to stop all local applications. Four intravenous injections of 4 mg. per kilo of mercurochrome were given, also without improvement. Then 5 c.c. of 1 per cent antimony and potassium tartrate was given intravenously and in eight hours the patient, for the first time since the onset of the disease, was free from pain and enjoyed a perfect night's sleep without an analgesie. Gradually increasing doses on alternate days brought about a complete healing of the lesions.

Abstract of Papers Before University of Wisconsin Medical Society

C. D. LEAKE, EDITOR

DIATHERMY: ITS SCOPE IN MEDICAL PRACTICE

BY FRANZ NAGELSCHMIDT, M.D.

Berlin, Germany

The great modern development of physics, chemistry and technical industry, has offered a tremendous variety of new and untried agencies of possible value in medicine. Medical science has been reluctant to study the application of various physical agents to the treatment of disease, and this reluctance is in danger of resulting in the development of all sorts of quackery in this field. It is wrong for scientific men to ignore the possibilities of development in this line and it is time for careful and critical study of the exact effects of certain physical agencies on living tissues. In the development of physiotherapy, it is important that the specialist in this field be, in the first place, an excellent general practitioner, and in addition, he must be an expert physicist and mechanic. It is important that training courses in physiotherapy be carefully organized. Any tendency for physiotherapy to degenerate into a testimonial affair must be discouraged. It is also important to emphasize the fact that physiotherapy is not a panacea; it has certain distinct uses, certain contraindications, and certain severe limitations.

Examples of physiotherapy of more or less well established types are the use of radium and x-rays in malignancy. There has lately developed the use of alpha-rays for the treatment of certain skin diseases. The development of ultraviolet therapy has become of great popular interest and is in

Editor's Note: Clinical application of high frequency currents and ultraviolet light was first made by Dr. Nagelschmidt in 1907. His pioneer work has been instrumental in the remarkable development and interest in physiotherapy.

danger of being abused. A certain sense of responsibility is felt in regard to ultraviolet therapy, and any efforts to promote its employment as a general panacea are to be severely condemned. It is remarkable that such a small part of the spectrum, viz., that measuring about 3,000 angstrom units, is the portion of such great value. It has been shown to have a remarkable effect on calcium fixation, upon certain vitamines, and upon the vegetative nervous system. Its application to the skin results, if properly employed, in the stimulation of all the protective agencies elaborated by that great organ. Ultraviolet light does not penetrate deeply into the tissues and, as is well known, if too intense, may produce the death of the surface cells. The subsequent absorption of the products of decomposition from these dead surface cells may result in effects similar to those following the injection of a foreign protein. The infrared rays at the opposite end of the spectrum penetrate more deeply than the ultraviolet rays but, peculiarly enough, not as deeply as yellow rays.

Of great current interest is the matter of diathermy which may be defined as the application of high frequency currents for the purpose of inducing internal heat. This is an entirely different proposition from the external application of heat to the surface of the body. When ordinary low frequency or direct currents are applied to living tissue, there is an ionization in the tissue with a tendency to set up a flow of the ions toward the poles. This tendency is very slow. In the low frequency alternating current, the change in the direction of the flow may be sufficient to disrupt the cell, causing pain, discomfort, and all the other sensations following the ordinary application of an electrical current to the body. If the frequency of the alternating current is raised, the movement of the ions becomes progressively inhibited and, at about 10,000 alternations per second, is stopped. High frequency currents employ between 100,000 and 5,000,000 per second. This type of current was first applied to living tissue by D'Arsonval in 1901. After witnessing these preliminary trials, experiments were conducted on frogs with high frequency currents. With the electrodes applied to one arm and one leg, it was found that the skin gradually dried and that the muscular tissue between the electrodes became coagulated and cooked but, peculiarly enough, on removing the electrodes, the frogs were still able to move and apparently could continue to live indefinitely. Further experimental studies indicated that the tissues of the body, exactly as the filaments in a lamp, offer resistance to the passage of the high frequency current, and that heat develops. There is no sensation of pain, there is no muscular contraction, but merely the gradual development of a diffused heat between the points at which the electrodes are applied. The direction of the high frequency current is determined by the position of the electrodes. There are no chemical changes in the tissue nor any untoward reactions unless the current is extreme in intensity and duration. There is usually a hyperemia in the tissue between the electrodes, which is of an arterial origin.

In practice, a large indifferent electrode is usually applied to the back or abdomen and a smaller electrode is employed for concentrating the current and to secure proper direction. If this small electrode is edged and pointed in a manner similar to a knife, it may actually be used as a knife—"The radio knife" of newspaper reports. This knife acts by immediately coagulating and cooking the tissues with which it comes in contact.

The clinical applications of diathermy are very great. In the first place, by employing diathermic surgery, a bloodless operation may be made which is exceedingly valuable in removing carcinomatous tissue. It possesses a great advantage in inducing no hemorrhage, no pain, and in requiring no suturing. It also is advantageous because no blood vessels or lymph-channels are opened and there is thus no danger of inducing metastasis. The carcinomatous area is cooked, and surrounding this coagulated area is an area of hyperemia and increased metabolism which promotes healing and favors elimination. Clinical results with this technique have been very striking. Another important use of diathermy is in the treatment of lupus. Another interesting employment of diathermy is in connection with gonorrheal infections of the urethral tract. The gonococcus is apparently killed by a temperature slightly above the normal tissue temperatures, and sometimes very difficultly handled chronic infections of this type

(Continued on Page XXII.)

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FOR THE COUNTY SOCIETY

1. *Program Material.* Pursuant to authorization by the 1924 House of Delegates the Secretary is arranging to make program material available without cost. The following can now be secured:

A. Departmental Officers of the State Board of Health. Address Dr. C. A. Harper, State Health Officer, State Capitol, Madison, Wis.

B. Clinicians of the Wisconsin Anti-Tuberculosis Association when in vicinity. Address Clinic Dept., W. A. T. A., 558 Jefferson Street, Milwaukee.

C. Councilors and Officers of the State Society. Address the individual.

2. *Annual Statements.* Uniform annual statements can be had without cost. Address the Secretary, advising number desired.

EDITORIALS

EXAMINATIONS OF THE APPARENTLY HEALTHY

FEW public health doctrines are backed by stronger proof of their need for men, women and children of our time than the movement for periodic medical examinations of apparently healthy persons. This is grounded in common sense. It has as its primary motive the preservation of health, the prolongation of life, the security of the home. Merely to encourage it is an act of altruism by the physician which, although often ascribed to professional advantage, is yet based on the highest conception of his calling —the saving of human life.

That this principle of life preservation may be more generally accepted by the people requires that they look beyond the role of the physician as one who ministers only when sickness comes or the deathbed impends. Men have not yet learned to call the physician when they are well, or consider themselves so. The suggestion sounds to them unnecessary, uneconomic, advantageous only to the physician. "Am feeling fine, why worry, why borrow trouble? I live for the present; let tomorrow take care of itself."

Every man of ordinary judgment, however, knows better than this, for in other concerns of daily living we find him giving time and attention to preparedness. He takes his car to the mechanic to fortify it against unnecessary and costly breakdowns. His household heating plant gets periodic attention to insure against damage and to lengthen its life of service. The railroad company does likewise by constant supervision given its movable equipment.

As another type of machine, the human body is no less susceptible to injury or breakdown before its allotted time. Periodic examination to ascertain what points are weakest, what processes, habits and procedures will keep the body functioning with minimum expense and need for repair—this too is the logical course. Who benefits most from such a plan? Obviously the patient who conscientiously follows the advice of his physician is the chief beneficiary.

Mr. Homer Folk, a former president of the National Conference of Social Work, prophesied that, without further gains in our present knowledge of disease, twenty years can be added to the average span of life within the next half-century. By its nationwide program of preventive medicine, a great insurance company has effected a 28 per cent reduction of death rates. The world is full of examples of physical fitness as a foundation for a healthy old age.

No one who views the evidence of deaths from heart disease, apoplexy, cancer, etc., in middle and later life can escape the conclusion, however, that we have failed to teach preparedness sufficiently in the matter of the human physical plant. Deaths from the causes mentioned are mounting with startling progression. To halt them is the province of the physician. This is one of the purposes of periodic physical examinations. These methods offer the solution so far as human efforts may be brought to bear.

Physicians must keep pace with this demand for health not only by lending full encouragement to the movement but in being prepared to give a thorough and painstaking examination of the patient. This, and the instructions given, should increase his comfort and efficiency. It should be convincing as to its importance for his future well-being. When surrounded by such conscientious regard for the vital interests of the patient, such an examination can hardly fail to impress him that he has profited by the time and expenditure made.—*C. A. H.*

DISEASES IN INDUSTRY

THE danger of jumping to wrong conclusions from insufficient information is well illustrated by a recent investigation of a high tuberculosis death rate in a German rural district. At first, it seemed that work in the tobacco factories must be responsible. On further study, however, it was found that on account of the lightness of the work, physical weaklings sought that kind of employment and the investigators finally concluded that the greatest likelihood was that the disease was more likely to have been due to home infections than to conditions within the factories.

Similar conditions have been responsible, in this country and elsewhere, for giving many forms of really favorable employment undeserved bad reputations. That there are certain trades with unmistakable greater tuberculosis hazards is unquestionable. Such should, of course, be avoided by persons who have had tuberculosis family histories and probably intimate and prolonged contacts

which, probably, implanted obscure infections. And those strong resistant people who do accept such employment should be doubly watchful of the possibility of the disease. For them, particularly, periodic physical examinations should be a practical reality and not a theoretical health protection measure.—H. E. D.

THE PATHOGENESIS OF HYPERTENSION

THERE have been so many theories and so much speculation about the cause of hypertension that the discovery, in a carefully studied pathological series, of an anatomical basis for prolonged rise in blood pressure is more than welcome. The physiological causes of transient increase in blood pressure are well-known. The pathogenesis of prolonged, year in and year out, hypertension has eluded investigators. Here and there were suggestions that possibly the cranial arteries might be implicated in the cause, and even that the diminution of blood supply to the vital centers in the medulla might have a bearing upon the question. It remained for Anrep and Starling to show conclusively that reduction in blood supply to the medullary vaso-motor center (centers) occasioned sharp rises in blood pressure in dogs. Starling then suggested that this observation might have a bearing upon the human problem.

Stimulated by this suggestion Bordley and Baker* studied very carefully microscopic sections of the medulla at the location of the vaso-motor center in a group of hypertension and in a group of normal blood pressure cases. They selected the cases of hypertension from those patients whose histories and repeated blood pressure estimations showed that they had had hypertension for a long time. They studied 24 cases, 14 having blood pressure above 150 mm. Hg. and 10 having pressures below that point. The uniform finding in the hypertension cases was definite arteriosclerosis of the blood vessels in the medulla. They describe a typical case as follows: "Sections from the medulla oblongata showed arterioles considerably altered. The intima in most of them was fairly normal, although in several it was somewhat thickened. The media showed a variety of changes and in all the arterioles it was obviously thicker than normal; the muscle nuclei stained poorly. Fibrous tissue infiltrated through the media. In some arterioles the media had a homogeneous hyaline appearance; in others a granular deposit separated the muscle fibres of one side, forcing the lumen into an eccentric position, almost obliterating it."

Changes such as those described above were also found in the arterioles of the pia mater (where Gull and Sutton found them in 1872) in the spleen, pancreas and kidney. A striking feature was the localization of the arteriosclerotic process to certain vessels while other vessels in the immediate neighborhood seemed normal in appearance.

An observation of interest was that in the widespread atheromatosis of the senile type with scarred kidneys and low blood pressure the vessels of the medulla were not at all affected.

The authors suggest that the narrowing of the small vessels supplying the area of the vital medullary centers brings about a compensatory rise in general blood pressure in order to supply blood to these centers.

They do not claim to have solved the problem of the etiology of hypertension but they feel that they have found an anatomical explanation for it. Should others confirm this observation it will add another bit to our very imperfect knowledge of a very common and increasingly prevalent symptom-complex.—L. M. W.

*Bordley, James III and Baker, B. M., Jr.: A Consideration of Arteriosclerosis of the Cerebral Vessels and the Pathogenesis of Hypertension. Bull. Johns Hop. Hosp., 39:229, 1926 (Oct.).

RESERVE COMMISSIONS OFFERED

The Surgeon General of the Army desires to call the attention of all graduates in medicine to the opening now offered these gentlemen to form part of the National Defense by enrolling in the Medical Department Reserve. In this way one can become an officer of the Medical Reserve, entitled to regular army pay when assigned to active duty.

The organized reserves offer new associations and in their co-operation make successful the civic instructions in the Citizens Military Training Camps. It is something for the new graduate to think about as it immediately gives him a status of which he can be justly proud and in many instances leads to profitable contacts and work.

To learn more of this opportunity address the Commanding General, Sixth Corps Area, 1819 West Pershing Road, Chicago, Illinois, or consult office Chief of Staff, 101st Division, Organized Reserves, First Wisconsin Trust Building, 68 Wisconsin Street, Milwaukee, Wis.

THE PRESIDENT'S PAGE

Arthur W. Rogers

THE VALUE OF ORGANIZATION

After our editorial of last month it is pertinent to ask, why do we desire and need closer organization in the medical profession? It would be equally pertinent to inquire, why do we need and have state boards of health? It is only through organization that any great movement can be put over. As a rule, results are in proportion to the character of organization.

The medical profession of the country, consisting of several thousand men and women of varying educational, social, and personal qualifications, all supposedly striving for the same end, the relief of suffering and the prolongation of life, has in the past given too little heed to the influence they wield in the community and nation. Individually this influence is not great; but combinedly, it has no limitation. Realizing this, certain members of our profession have been responsible for the birth and existence of the American Medical Association. We have our state, county, and local societies, but the rank and file of these societies are complacently permitting a few to carry on the work.

Large industries today are selling their stocks to their employees. The answer to this practice is patent: to make them partners, improve morale, increase individual interest, and stimulate production.

We, as members of our constituent medical organizations, are partners in them; therefore, it is not only our pleasure but our duty to attend their sessions, to participate in their activities and strive for their growth and development. As the society grows, so will we.

In the past too much emphasis has been laid upon "what can the society do for me?" and too little thought given to our responsibility to the society. It is at least a fifty-fifty proposition. Why do we seek membership in our county medical society? Because outside of it we have no standing. If so, why should we not give more of our time, thought, and effort to our society's activities? Do this, and watch our profession improve, our societies grow, and our personal interests expand.

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SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

Dr. E. S. Schmidt, Green Bay, was elected president of the Brown-Kewaunee County Medical Society at the annual election of officers. Dr. R. W. Kispert was chosen vice-president and Dr. M. H. Fuller is the new secretary and treasurer.

The dinner meeting held at the Northland Hotel, Green Bay, on Tuesday evening, December 28th, was attended by about twenty-five of the Brown-Kewaunee Society members and, following the election, plans were made to entertain Dr. Morris Fishbein, editor of the American Medical Journal, who will speak before the Rotary Club noon meeting on January 6th.

Following the business session, Dr. R. L. Cowles, who recently returned from abroad, read a paper on "Diagnosing Diseases of Children." The paper was excellently prepared and was illustrated by lantern slides. At the conclusion of the talk, the subject was discussed thoroughly by the physicians present.

Under date of January 6th, the members of the county society, the Green Bay Academy of Medicine, together with members of the Brown County Dental Society, met at the Northland to hear Dr. Morris Fishbein of the American Medical Association. Dr. Fishbein gave his audience an hour and a half of interesting information on "Twenty-Five Years of Medical Progress." The talk was plentifully interspersed with a dry, sometimes biting wit, which elicited much laughter.—M. H. F.

DANE

At a dinner meeting of the Dane County Medical Society on December 28th, Dr. W. D. Stovall, Madison, was elected president of the society; Dr. W. J. Bleckwenn, Madison, vice-president, and Dr. H. H. Reese, Madison, secretary-treasurer for the coming year. Dr. H. P. Greeley was appointed delegate to the state meeting. Dr. H. M. Carter, alternate, and Dr. R. Jackson was chosen as censor.

Speakers of the evening were Dr. H. P. Greeley, who discussed the surgical aspects of diabetes melitus, and Dr. F. J. Hodges, who spoke on the subject of limitation of x-ray examinations in diagnosis.—H. H. R.

DODGE

The Dodge County Medical Society held their last meeting of the year at the Lutheran Deaconess Hospital, December 16th, at eight o'clock. Dr. Louis F. Jermain of Milwaukee conducted a clinic, demonstrating the following cases: Actinomycosis of the Lung; Paget's Disease; Dysfunction of the Pituitary; Nephritis; Infection of the Kidneys (Staphylococcus).

Following the clinic, officers were elected for the year 1927. The new officers include: President, Dr. L. Bachhuber, Mayville; vice-president, Dr. E. P. Webb, Beaver Dam; secretary, Dr. A. A. Hoyer, Beaver Dam; censor, Dr. H. M. Holtz, Beaver Dam.

A resolution was passed acknowledging the long and useful service of the late Dr. H. B. Sears, whom death recently took from their midst, and extending sympathy to members of the family. The late Dr. Sears was a member of the Dodge County Medical Society for many years.—A. A. H.

DOUGLAS

At the annual meeting of the Douglas County Medical Society, the following officers were elected for the ensuing year: President, Dr. P. G. McGill; vice-president, Dr. J. R. Goodfellow; secretary-treasurer, Dr. J. W. McGill; censors, Drs. L. W. Beebe and C. H. Mason; Delegate to the state convention, Dr. T. J. O'Leary, all of Superior.—J. W. McG.

FOND DU LAC

The members of the Fond du Lac County Medical Society met in annual session at the Hotel Retlaw, Fond du Lac, on December 9th. New officers elected for the coming year were: President, Dr. D. N. Walters; vice-president, Dr. J. E. Twohig; secretary-treasurer, Dr. H. R. Sharpe; delegate to the state meeting, Dr. S. E. Gavin, and alternate, Dr. H. R. Sharpe.

Following the meeting a banquet was held in the Empire room of the hotel, after which Dr. F. J. Gaenslen of Milwaukee gave a very constructive talk on "Osteomyelitis."—D. N. W.

GRANT

The members of the Grant County Medical Society are planning a banner year in the history of their society. They will have another meeting for the Fourth Councilor District, with the cooperation of the societies of Iowa, Crawford, LaFayette and Richland counties. And best of all, they will celebrate their twenty-fifth anniversary as a society, a silver jubilee, with appropriate ceremonies. The programs for the regular meetings of the society will also be more instructive and interesting than ever before.—M. B. G.

KENOSHA

The Kenosha County Medical Society met at the Elks' Club in December to elect new officers for the year. Dr. C. G. Richards was chosen president; Dr. E. F. Swarthout, vice-president; Dr. Helen Binnie, secretary-treasurer; Dr. W. C. Stewart, member of the board of censors. Dr. G. F. Adams was elected delegate to the State Medical Society meeting and Dr. C. R. Caughey was chosen alternate.

At the January meeting, held on the 21st day of the month, Dr. L. M. Warfield, Milwaukee, spoke to the members on "Thrombosis of the Coronary Arteries."

—H. A. B.

MARATHON

The annual meeting of the Marathon County Medical Society was held at the Wausau Memorial Hospital on December 29th. Dr. J. E. Rueth, Milwaukee, addressed the physicians on "Physical Therapy in Chronic Lumbar Pain." The election of officers resulted in the following: President, Dr. Wm. E. Zilisch; vice-president, Dr. S. M. B. Smith; secretary-treasurer, Dr. Verne E. Eastman; delegate, Dr. J. M. Freeman; censor, Dr. J. N. Doyle; and member Dispensary Committee, Dr. D. T. Jones.—V. E. E.

MARINETTE-FLORENCE

The members of the Marinette-Florence County Medical Society met at dinner at "The Old English Grill," Marinette, on Thursday evening, January 20th. Dr. Stanley J. Seeger, Milwaukee, was the speaker of the evening. His subject was "Appendicitis in Infancy and Childhood." Reports were made by the president and secretary on the Council Meeting and the Secretaries' Conference in Milwaukee during January.—M. D. B.

OUTAGAMIE

The annual meeting of the Outagamie County Medical Society was held on December 17th at the Hotel Northern, Appleton. The business meeting was called to order by President Dr. C. E. Reineck, the minutes of the previous meeting and the secretary-treasurer's report were read and approved. The following physicians were elected to office for the year 1927: Dr. J. B. MacLaren, president; Dr. Wm. J. Frawley, vice-president; Dr. C. D. Neidhold, secretary-treasurer; Dr. C. E. Reineck, censor; delegate to the State Medical Society meeting, Dr. V. F. Marshall; and alternate, Dr. J. J. Laird.

Following the business meeting a banquet was served at which about thirty doctors and their wives participated. The Rev. J. A. Holmes of the First Methodist Church, was the speaker of the evening, his subject being "The Doctor." Dr. Holmes' address was very fine indeed.

The regular January meeting of the Society was held on Thursday evening, January 20th. at the Hotel Northern, Appleton. Dinner was served at 6:30. There were twenty-two members present.

Important matters of business were discussed and the business meeting was followed by a talk from both the school and county nurse. A very interesting and complete paper on "Loose Bodies of the Knee Joint and Their Surgical Removal" was read by Dr. V. F. Marshall. This program was put on by local talent exclusively.—C. D. N.

RACINE

The annual meeting of the Racine County Medical Society was held in the class room at St. Mary's Hospital, Thursday, December 9th, at 4:00 p. m. The following officers were chosen to serve for the coming year: President, Dr. W. A. Prouty, Burlington; vice-president, Dr. W. C. Hansen, Racine; secretary-treasurer, Dr. Susan Jones, Racine; censor, Dr. W. P. Collins, Racine. Dr. G. W. Nott was elected delegate to the state convention and Dr. H. B. Keland, alternate. Dr. L. M. Warfield, Milwaukee, gave a splendid address on the subject of "Cardio-Renal Diseases."—S. J.

ROCK

Dr. W. H. McGuire, Janesville, was elected president of the Rock County Medical Society at the December meeting held at Beloit. Other officers are: Dr. Harold Helm, Beloit, vice-president; Dr. H. E. Kasten, Beloit, secretary and treasurer; Dr. T. W. Nuzum, delegate for two years, and Dr. P. A. Fox, alternate.

Following the regular order of business, an interesting lecture was given by Dr. C. E. Yaeger, eye, ear, nose and throat specialist of the staff of Cook County Hospital, Chicago. His subject was "Complications of Acute Otitis Media."—H. E. K.

SHEBOYGAN

At the annual meeting of the Sheboygan County Medical Society, held December 11th, the following officers were chosen for the ensuing year: Dr. C. A. Squire, president; Dr. H. C. Heiden, vice-president; Dr. G. J. Juckem, secretary-treasurer; Dr. A. K. Knauf, delegate; Dr. F. A. Nause, alternate; Dr. O. T. Gunther, censor for three years.

On motion by Dr. O. B. Bock, councilor of the Fifth District, the society voted unanimously as being in favor of the election of the district councilor at one of the district meetings.—H. C.

WAUKESHA

The members of the Waukesha County Medical Society were entertained on December 1st by Dr. B. M. Caples at his sanitarium in Waukesha and enjoyed a delightful dinner. The officers for the new year were chosen preceding the dinner. They include: President, Dr. C. C. Edmondson, Waukesha; vice-president, Dr. H. T. Barnes, Delafield; secretary-treasurer, Dr. J. F. Wilkinson, Oconomowoc; delegate, Dr. M. R. Wilkinson, Oconomowoc; alternate, Dr. F. C. Rogers, Oconomowoc; board of censors, for three years, Dr. H. T. Barnes, Delafield; for two years, Dr. J. B. Noble, Waukesha; for one year, Dr. J. F. Wilkinson, Oconomowoc.

Following the dinner, Dr. L. F. Jermain, Milwaukee, delivered the address of the evening on the subject of Periodic Examination of the Apparently Healthy. (Editor's Note—A summary of this address will be published in a succeeding number of the Journal.)

MILWAUKEE ACADEMY

The annual business meeting of the Milwaukee Academy of Medicine took place on Tuesday, January 11th. It was preceded by a steak dinner in the main dining room of the University Club. The newly elected officers for the ensuing year follow: President, Dr. G. A. Carhart; president-elect, Dr. A. W. Rogers; vice-president, Dr. J. S. Gordon; secretary, Dr. D. E. W. Wenstrand; treasurer, Dr. R. P. Sproule; librarian, Dr. E. A. Smith; members of the council, Drs. R. W. Blumenthal, H. R. Foerster, C. H. Davis, S. J. Seeger, A. J. Patek, C. A. Evans. The following committees were also announced: Auditing, Drs. J. S. Gordon, C. H. Fellman and A. M. Dorr; library, Drs. F. H. Haessler, R. M. Greenthal and W. J. Egan; program, L. M. Warfield, F. D. Murphy and J. J. Pink.

Dr. N. M. Federspiel, Milwaukee, presented a very instructive paper on "Demonstration of a Case of Cleft Palate" at the last meeting of the month. Dr. Arthur T. Holbrook spoke on "Biologic Considerations in the Handling of Disease."—D. E. W. W.

MILWAUKEE NEURO-PSYCHIATRIC

The members of the Milwaukee Neuro-Psychiatric Society enjoyed a very interesting and instructive program at their January meeting held in the Medical Arts Building. Dr. George W. Hall, of Chicago, spoke on the subject of "Nonspecific Protein Therapy in General Paresis" and Dr. H. H. Reese, Madison, presented a paper on "Treatment of General Paresis at Nonne's Clinic at Hamburg."—W. T. K.

MILWAUKEE OTO-OPHTHALMIC

The annual meeting of the Milwaukee Oto-Ophthalmic Society was held Tuesday evening, January 18th, at the University Club. The business meeting preceded the dinner which was followed by two addresses. Dr. Henry B. Hitz, Milwaukee, presented a paper on "The Fossa of Rosenmueller" and Dr. Thomas L. Tolan, Milwaukee, spoke on "Some Rhinologic Manifestations of Pelvic Conditions."—E. R. R.

NINTH COUNCILOR DISTRICT

The mid-winter meeting of the Ninth Councilor District, held at Marshfield on January 14th, was well attended. The session opened in the afternoon with a clinical demonstration at St. Joseph's Hospital. Dr. K. W. Doege spoke on "Resections of Stomach;" Dr. K. H. Doege, on "Diabetes" and Dr. H. H. Milbee on "Encephalitis." At the conclusion of the afternoon program the gathering repaired to the Guild Hall for the dinner.

The meeting was resumed at eight o'clock at the new clinic building when the following program was carried out: "The Use of the Kiell and Obstetrical Forceps, Demonstration on the Manikin," Dr. J. B. Vedder; "The Importance of Post Mortem Examinations for the Practitioner," Dr. Edward L. Miloslavich, Milwaukee; "The Diagnosis and Treatment of Bladder Tumors," Dr. Daniel Eisendrath, Chicago; "Exhibit of Roentgenological Films," Dr. R. P. Potter.

The spring meeting of the district society, at which new officers will be elected, will be held in Stevens Point.—J. F. S.

NEWS ITEMS AND PERSONALS

Drs. E. L. Bolton and E. F. Mielke have just moved into a nine-room suite on the second floor of the Insurance Building, Appleton. Each doctor now has his own consultation and dressing rooms which adjoin each other. The laboratory has been placed in charge of Miss W. Brouhard, a technician formerly with the Minneapolis General Hospital. Drs. Bolton and Mielke have been associated for about four years.

Dr. F. A. Southwick, Stevens Point health officer, read an address on tuberculosis from radio station WLBL a short time ago. The talk emphasized the need of local communities to give aid to their tuberculous people, as found after an investigation by the National Masonic Tuberculosis Sanatoria association which reports that southwestern communities are overburdened with sick people unable financially to provide for themselves.

Dr. Russell M. Kurten, Racine, was named as school examining physician by the board of health as announced by Dr. W. W. Bauer, head of the department. The position was created by the city council recently when an amount to cover the salary was included in Dr. Bauer's budget. Dr. Kurten assumed his new duty on January 1st.

J. Allen Wilson, Appleton, student in the University of Wisconsin Medical School, ranked third in the September nation-wide examinations of the National Board of Medical Examiners, it has just been announced.

Successful passing of the examinations qualifies candidates for appointment in the medical service of the army and navy of the United States and to practice in many states of the Union. First place in the September examinations went to a student of Harvard Medical School, and second place to a student of Johns Hopkins University. Allen Wilson was the only student to receive a grade of 100 in any one subject.

Dr. T. J. Hambley, Hurley, who has practiced in the Cary location for the past twenty-five years, left recently for Ramsey, Michigan, where he will take up new duties with the Oglebay Norton Company. Dr. Hambley came to Hurley from Chicago in 1898 and a few years later was established as mine physician at the Cary mine where he has resided with his family continuously.

Dr. R. B. Smiley, for twenty years a practicing physician in Stevens Point, has decided to establish his practice in new fields. The doctor has not definitely decided upon a new location but it probably will be in some western city.

Dr. W. A. Deerhake of the Central State Hospital for the Insane, Waupun, told the local Rotary Club recently of his trip made to inspect eastern institutions for the care of defectives and criminals. Dr. Deerhake declared that the State Hospital, managed as it was when he took charge, ranked well when compared with other institutions.

Dr. E. P. Crosby, Stevens Point, has returned to his home from the Mayo Clinic, Rochester, Minn., where he has spent a number of weeks in an effort to recover his health. It was reported that it would not be necessary for him to return to the clinic inasmuch as he is making a satisfactory recovery.

Dr. G. R. Reay, for the past five years county physician of La Crosse, gave an interesting and informative talk on the duties of a county physician at the January meeting of the League of Women Voters recently. The whole duty of a county physician is to take care of people after they are classed as county dependents and not before. The poor commissioner is the only official in a position to tell the county physician whom to care for and when this doctor has been put in charge of a case he himself is the sole judge of what should be done for the patient.

Early recognition of cancer by periodic physical examinations will do much to eradicate the disease, according to Dr. Alton Ochsner, associate professor of surgery at the Wisconsin General Hospital, who spoke before the American Business Club at a luncheon recently.

The annual meeting of the staff of St. Elizabeth Hos-

pital, Appleton, was held on Tuesday evening, January 4th, following the annual dinner at 6:30 served by the Sisters at the hospital. Dr. C. E. Ryan was elected chairman and Dr. G. W. Carlson, secretary-treasurer for the ensuing year.

Three of the four physicians to be added to the Milwaukee public school medical department have been appointed, according to a recent announcement, by the city service commission. They are Drs. J. B. Willets, P. H. Perlson, and J. A. Jenner.

The school physicians work under the general direction of Dr. G. P. Barth, chief of the school medical department, and Health Commissioner J. P. Koehler.

Dr. C. E. Smith, Beloit, has left that city for Florida where he and his wife will spend several weeks before taking the Southern Trail to California, to spend the winter on the west coast. The Smiths will tour the state of California by auto and also will tour northward through Oregon and Washington to return to Beloit about May 1st.

Dr. Smith has sold his interests in the Beloit Clinic to Dr. C. N. Dawson, who has been with the clinic for six months. Dr. Dawson has taken over Dr. Smith's office in the hospital building and will continue the doctor's work there.

Dr. J. P. Koehler, health commissioner of the city of Milwaukee, spoke on "Milwaukee's Health" recently at the weekly luncheon of the Professional Men's Club at the Milwaukee Athletic Club.

Dr. W. W. Crockett was elected president of the Beloit Physicians' and Surgeons' Club at the annual meeting and election of officers held at the Y. M. C. A. in January. Dr. F. A. Thayer was chosen vice-president and Dr. L. M. Field was re-elected secretary and treasurer.

"As the best work is done in the shops equipped to give expert service, so physicians can do their best work in modern hospitals," said Dr. J. M. Dodd of Ashland, speaking to the Lions Club at a recent luncheon. Doctors are coming more and more to insist on hospital facilities, he declared, and are doing less work in the homes, realizing the superior advantages that the hospitals offer the patient.

Dr. F. Z. Havens, formerly of Waupun, who received a fellowship at the Mayo Clinic at Rochester, Minn., nine months ago, has accepted a permanent position in the department of laryngology and oral and plastic surgery at the institution.

Dr. George P. Barth, Milwaukee, explained the operation of the County Psychiatric Clinic at a January meeting of the Optimist Club. Dr. Barth is one of the city school physicians.

"The Internship in the Practice of Medicine" was the subject of an address by Dr. Edward Evans of La Crosse before members of the Circle, honor society of the Marquette University School of Medicine, at a dinner at the Medford Hotel. Dr. Evans is surgeon chief at St. Francis Hospital, La Crosse.

Dr. T. L. Harrington, Milwaukee, consulting physician of the Oak Forest Sanatorium, recommended in a meeting of the Committee on County Institutions of the county board of supervisors that the sanatorium be relieved from the false economy under which it has been operated for a number of years. No criticisms were made by the physician except in the matter of efficiency. A competent head nurse to relieve the superintendent of some of her duties was suggested. The superintendent is at present doing both the work of the head nurse and her own duties.

Delving "beneath the labels" of many widely-known and nationally advertised patent medicines and showing their absolute worthlessness by an inspection of their ingredients, Dr. A. S. Loevenhart of the University of Wisconsin described how such preparations are sold in large volume to gullible people, in an address before the Madison Gyro Club at the Loraine Hotel.

Dr. Loevenhart illustrated his address with stereopticon slides showing close-up views of labels, directions, advertisements, and testimonials. Letters written in all confidence to patent medicine concerns have been confiscated by government officials when closing up the affairs of such companies, he said, later being turned over to letter brokers and re-sold to other similar fake concerns.

The address was replete with humor and Dr. Loevenhart gave his hearers much information concerning the high alcoholic content of several well-known tonics.

Dr. T. L. Harrington, Milwaukee, who with others of the staff of the Wisconsin Anti-Tuberculosis Association, were conducting a clinic in the city of Manitowoc, addressed the Kiwanis Club of that city recently. His subject was public health work in the state of Wisconsin.

In addressing the Janesville Lions Club during January, Dr. Gerald K. Wooll outlined the characteristics of various narcotic drugs, urged parents to train their children to beware of strangers who offer anything to taste and told members of the club that proper legislation should be promoted to curb the "curse" drugs are leaving everywhere.

Dr. Wooll said that of all narcotics, heroin is the worst. He stated that it has ten times the strength of morphin, and has much the same effect as the latter drug except that it causes more intense excitement.

Dr. Oscar Heyer who, for the past year, has been associated with the physicians of the Reedsburg Hospital, left recently to accept a position as senior resident physician in the Muirdale Hospital at Wauwatosa.

The League of Nursing Education and the Seventh District Nurses Association held their January meeting at the Nurses' Home of St. Francis Hospital, La Crosse. Dr. Edward Evans of the St. Francis staff gave a

résumé of nursing in past years and traced the work to the present date. He compared nursing in this country with that of foreign nations. Lively round table discussion following his talk bespoke the enthusiasm with which it was received.

Dr. Herbert H. Christensen, Wausau, has just announced the opening of a new office in Suite 312, American National Bank Building. Dr. Christensen was formerly associated with Dr. Joseph F. Smith of that city.

Drs. I. E. Schiek and A. F. Harter, Rhinelander, have announced the opening of new offices in the Merchants' State Bank Building. The physicians are contemplating the organization of a clinic in the near future.

Dr. James J. Dinsdale, Soldiers Grove, a graduate of Rush Medical College, Chicago, class of 1878, served long and faithfully as a physician, highly esteemed by his patients and friends. But now, owing to feeble health, he has been unable for several years to continue the practice of medicine. His fellow physicians of Crawford County elected him, some time ago, a member emeritus as a reward for his honorable work in the profession.

Dr. Conrad Tasche was re-elected president of the Sheboygan clinic at the annual meeting held in the clinic building Thursday evening, January 20th. Dr. Otto Guenther was re-elected vice-president. Members of the board of directors, all of whom were re-elected, are: Drs. William Guenther, G. H. Stannard, A. E. Genter, O. A. Fiedler, William Van Zanten, Harry Heiden, Conrad Tasche, John Tasche, J. P. Zohlen, C. A. Squire and Otto Guenther.

Dr. J. W. Lowe, formerly of Taylor, has taken over the practice of Dr. L. J. Walker of Merrillan. Dr. Walker will pursue a course in post-graduate work.

At a recent meeting of the staff of St. Mary's Hospital, Green Bay, Dr. R. L. Cowles was elected president. Dr. T. J. Oliver was chosen vice-president for the coming year and Dr. A. J. McCarey was named secretary and treasurer. Attorney A. McComb of Green Bay addressed the staff on "The Physician's Pedestal."

DEATHS

Dr. William Foote Whyte, Madison, died at his home on December 25th. While it was known that Dr. Whyte had not been in the best of health for some time, the sudden termination of his illness was not anticipated by his acquaintances. Dr. Whyte was 75 years old at the time of his death. He was born in Kinross, Scotland, in 1851, and came to America at the age of four, his family settling at Watertown. He worked his way through Northwestern Medical School, from which he was graduated in 1873, and served an internship at Mercy Hospital, Chicago.

He practiced medicine in and about Watertown from the beginning of his career until 1914 when he came to Madison to reside. He performed medical duties at Camp Custer and Camp Dix during the World War with the rank of first lieutenant. He was appointed to the State Board of Health in 1898 and was reappointed continuously until 1924 when he resigned. He became president of the Board in 1903 and continued for twenty-one years as its president. He was curator of the Wisconsin Historical Society and wrote a number of historical sketches on Wisconsin historical subjects.

Dr. Whyte was an honorary member of the Dane County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his wife, two sons and a daughter.

Dr. Roscoe S. Plumlee, Brooklyn, died on December 30th at his home in that city. Dr. Plumlee was born in the state of Tennessee in the year 1865 and was graduated from the University of Louisville School of Medicine in 1894. He began practicing in the state of Wisconsin in 1913.

Dr. Plumlee was a member of the Dane County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. Surviving him are his wife and four daughters.

Dr. Francis J. Pope, Racine, died at St. Mary's Hospital on January 1st as result of a stroke of paralysis. Dr. Pope was born in Alleghany, Pa., November 2, 1852, and was a graduate of Rush Medical College, Chicago, in the year 1875. For one year he practiced medicine in Chicago and then came to Racine where he continued in the practice of medicine for more than half a century. Dr. Pope served as a member of the city board of health and of the board of education of Racine. He was a member of the executive staff of St. Mary's hospital and served on the pension board of Racine County.

Physicians with whom he had been closely associated for many years were the pallbearers. They were: Drs. Soren Sorensen, E. L. Tompach, H. J. Brehm, G. W. Nott, L. E. Fazen, and J. H. Hogan, all of Racine. Dr. Pope is survived by his wife and six children.

Dr. John E. Armitage, Kohler, died Thursday morning, January 6th, at a La Crosse hospital following an operation. He was thirty-nine years old Christmas Day and graduated from the Marquette University School of Medicine in 1915. Dr. Armitage was formerly connected with the Physio-Therapy Department of the United States Veterans' Bureau, Milwaukee, and came to Kohler in 1925 where he was associated with Dr. M. D. Cottingham of the medical department of the Kohler Company.

The deceased was a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He is survived by his wife and two brothers.

Dr. T. R. Welch, Rhinelander, died of pneumonia at his home on January 18th. Born in Necedah in 1867, he received his early education in that city and in 1895 was graduated from Rush Medical College, Chicago, as valedictorian of his class. He came to Rhinelander in the year 1898 and made his home in that city ever since. Dr. Welch is survived by his wife.

Dr. Charles F. Rehling, Fremont, passed away sud-

denly on January 18th at the home of a patient. Death was due to a heart attack. The deceased was born in Fort Wayne, Ind., on June 26, 1873. Following his education in the schools of that city, he attended Purdue University, Lafayette, Ind., where he was graduated from the pharmacy course. He later attended Rush Medical College, Chicago, from which he graduated in the year 1906.

Dr. Rehling lived in Salt Lake City, Utah, but then came to Medinah before taking up residence at Fremont, where he has practiced medicine for more than seventeen years. Surviving him are his wife, two daughters, two brothers and one sister.

Dr. Rehling was a member of the Waupaca County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Dr. Harrison A. Rouse, Browntown, died on Saturday, January 22nd, at his home, following an injury to a limb received some time ago. Dr. Rouse was born September 1, 1864 at Albia, Iowa, and was a graduate of Rush Medical College, Chicago. He practiced in Michigan before coming to Browntown, where he has resided for many years. He is survived by his wife and one daughter, a student at the University of Wisconsin.

Dr. Rouse was a member of the Green County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

CORRESPONDENCE

REPORTS WANTED

January 15, 1927.

J. G. Crownhart, Sec'y.-Managing Editor,
The Wisconsin Medical Journal,
153 Oneida St.,
Milwaukee, Wisconsin.

My dear Mr. Crownhart:

I have sent out the enclosed questionnaire and have received approximately 600 replies from over 1,900 letters sent. It may be that those who failed to reply have had no cases but the subject is so important and it is so desirable to have the information not later than February, it occurred to me that you might carry a notice in your Journal, possibly a copy or extract of the circular letter that was sent out, and ask for further cooperation on the part of the physicians in Wisconsin.

With kindest regards, I am,

Very truly yours,
W. F. Lorenz, M.D., Director,
Wisconsin Psychiatric Institute.

UNIVERSITY OF WISCONSIN
WISCONSIN PSYCHIATRIC INSTITUTE
Madison, Wisconsin

December 13, 1926.

My dear Doctor:

Will you kindly indicate on the enclosed return postal card the number of encephalitis cases with residuals that have come to your notice during the last year or so?

We have had quite a large number of these severe nervous conditions sent in to the Wisconsin State General Hospital. These cases require special facilities for proper care and treatment. We are anxious to learn how large this problem is likely to be in Wisconsin.

The cases we are interested in are usually referred to as post-encephalitis or residuals from epidemic encephalitis, also referred to formerly as lethargic encephalitis. These post-encephalitic conditions quite commonly appear as a Parkinson's disease. The usual clinical picture being that of rigid muscles, fixed, masklike face, slow, incoordinated muscle movements, sometimes marked tremors, stiff, falling gait, arms not swinging as in normal gait. Sometimes the condition is limited to one side of the body. Many cases are practically bedridden and almost wholly unable to move about.

It may become necessary in Wisconsin to provide for such cases, especially when these are found among those who cannot afford long invalidism at home, so your opinion as to the likelihood of any cases becoming a County or State charge will help greatly to give us some estimate of the size of this problem in Wisconsin.

Your cooperation in this will be greatly appreciated.

Very truly yours,
W. F. Lorenz, M.D., Director,
Wisconsin Psychiatric Institute.

REPORT BLANK

Date....., 1926

	Mild	Severe
No. of post-encephalitic cases under your care	.....	.....
Total No. of post-encephalitic cases seen by you during the last two years	.....	.....
No. of cases likely to require hospitalization by County or State	.....	.....

NOT NEW

Milwaukee, Wis.
Jan. 13, 1927

Mr. J. G. Crownhart,
Managing Editor,
Wisconsin Medical Journal.
Milwaukee, Wis.

My dear Mr. Crownhart:

I noticed in your last Journal an item on Alpha Lobelin, as a new remedy for Monoxide Poisoning. I am sure it is not new. Statistics show that more than three hundred hospitals scattered over the country, especially in the East, have used it for a long time. I enclose a clinical report,* which is self-explanatory. I have used it with success. I hope this will lead others to use it. The remedy has been tried and tested, for all respiratory collapses, with success.

One need not go to Europe to learn about it.

Very truly yours,
Dr. Chas. A. Faber.

"ORIGINAL"

La Crosse, Wis., Jan. 15, 1927.

Mr. George Crownhart,
Wisconsin Medical Journal,
Milwaukee, Wisconsin.

Dear George:

I want to compliment you on the supplementary num

*Studies in Alpha-Lobelin Resuscitation, Reichle and Peters, 4th Annual Congress of Anesthetists, May, 1925.

ber which you published with the December issue of the Wisconsin Medical Journal. It will certainly mean a lot to the doctors in the state, due to the plainness with which you have outlined the various laws by which we are bound. I think we are quite original in this as I do not believe any other State Society has published a supplementary issue which is of such aid to the practitioners of the state.

Wishing you success in the New Year, I remain,

Sincerely,

J. A. Bigler, M.D.

Governor Fred R. Zimmerman has placed many new people in important state positions and still has many more appointments to make before the first year of his administration comes to a close.

The executive's latest appointments included the reappointment of Lewis Gettle as chairman of the state railroad commission; the appointment of Dr. Benjamin Davis, Pewaukee, as commissioner of agriculture: Robert Wild, Milwaukee, on the University Board of Regents; A. W. Kimball, Marquette county, as tax commissioner; M. A. Freedy, Milwaukee, insurance commissioner; Miss Harriet Grim, Darlington, as a member of the Board of Control; Robert Reiser, Madison, executive counsel; Charles W. Schwenker, Chippewa Falls, as state banking commissioner; Joe T. Nemachek, La Crosse, as a member of the state highway commission and R. W. Dixon, Eau Claire, as prohibition commissioner.

* * *

Dr. A. J. McDowell, Soldiers Grove, Crawford county, is the only physician to serve in this session of the legislature. Usually there are three or more physicians in the legislature. Dr. McDowell is serving his second term in the lower house. For the past twenty-eight years he has been practicing medicine at Soldiers Grove.

* * *

Senator V. S. Keppel, Holmen, has introduced a bill in the legislature repealing the old law which prohibits the employment of women in the legislature. Women have started an active drive to admit members of their sex to such positions as clerk.

* * *

Although progress in the fight against bovine tuberculosis is slow it is only a matter of time until the disease is completely eradicated, according to Dr. James S. Healy, who is in charge of tuberculosis eradication work in Wisconsin.

"The infection is relative in Wisconsin," Dr. Healy declared. "In the parts of the state where interchange of livestock has been going on for many years, heavier infection will be found. We have found very little infection in the newer parts of the state. A survey of the northern counties of the state has shown that tuberculosis exists there to a limited degree."

* * *

Legislators who have become interested in the growing popularity of bread and water diets for prisoners in other states, have found that there is little possibility of enacting such provisions in Wisconsin.

Bread and water diets were once popular in Wisconsin jails for men convicted of vagrancy. This diet is now being used in some states for prisoners convicted on liquor charges.

Legislators found that the Wisconsin supreme court in a decision in 1885 raised a question as to the constitutionality of a bread and water diet of 15 days for prisoners although it did not rule on the question as it was not before the court.

* * *

The board of control has no power to pay claims against the estate of a deceased convict, Attorney General John Reynolds held in an opinion to the state board of control. Probate proceedings must be instituted and the claims presented in the usual manner.

* * *

A study of taxation made by B. W. Allin, instructor in the college of agriculture of the University of Wisconsin, shows that the farmer and not the man in the city is the biggest sufferer from taxation increases. The burden of taxes on the farm has increased much more rapidly than the tax burden of city people, Mr. Allin found. Taking the single year of 1924, Mr. Allin found that 24 per cent of the net incomes of Wisconsin farms went for taxes while only 6.5 per cent of the net incomes in cities and 5.9 per cent of the net incomes of villages went for taxes. He also found that there had been practically no income taxes from farmers. Out of the average farm tax of $220, Mr. Allin found, $205 was a real estate tax and about $15 a tax on personal property.

Analyzing all incomes, Mr. Allin found that bankers had the highest with 28 in Dane County averaging $12,100 a year. Next in prosperity were merchants and manufacturers and then lawyers.

* * *

Assemblyman Alvin Reis, Madison, has introduced a plan for the appointment of two committees to study forestry and water powers in the state and report back to the legislature in April so that a comprehensive plan of conservation can be enacted. Each of the committees would be composed of two senators and three assemblymen. Mr. Reis declared that with many plans bound to be introduced in the legislature for conserving of these two branches of resources he believed his resolutions would bring a unified drive.

* * *

The first wet measure to come before the legislature is a resolution by Assemblyman Frank Prescott, Milwaukee, asking congress for a nation-wide referendum on modification of the Volstead act. Prescott declares that it is

only by a national referendum that it can be definitely told how people of the United States feel toward prohibition.

* * *

The Wisconsin legislature organized on January 12th. Senator W. L. Smith, Neillsville, was elected president pro-tempore of the senate and O. G. Munson, Viroqua, as chief clerk. In the house Assemblyman John W. Eber, Milwaukee, was chosen speaker and C. E. Shaffer, Madison, re-chosen for the twelfth time as chief clerk.

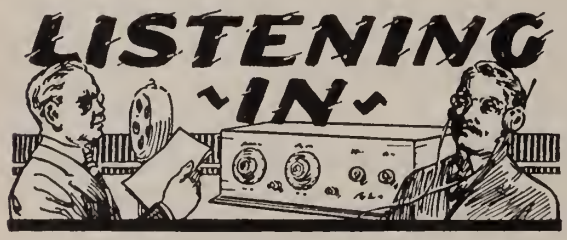
* * *

A boy removed from the state public school at Sparta to which he had been sentenced but who was removed on the grounds that he was feeble-minded automatically returns to the institution when he is declared mentally sound, Attorney General John Reynolds held today in an opinion to the state board of control.

The boy in question was sent to the northern colony and training school when he was declared feeble-minded but he was again examined and found mentally sound. He will be returned to the original place of commitment.

* * *

A law passed at the last session of the legislature providing that in a damage action brought against an out-of-state automobile driver, the secretary of state shall be the legal officer to accept service, was sustained in an opinion by the state supreme court. Before the passage of this law it was necessary to get service on the individual while he was in the state. This is no longer necessary as service on the secretary of state brings him directly before the courts.



NURSE WOULD VIOLATE LAW

A member writes that he has been requested to prescribe an ounce of two per cent solution of cocaine for the use of a nurse employed by an industrial plant. He stated the nurse did not work under the direction of a physician and intended to use the solution in the removal of foreign bodies from the eye. The member stated he had written the compensation insurance company who had responded that he should give the prescription. He asked the State Society if it were legal.

He was advised that a nurse attempting to remove foreign bodies from the eye without immediate direction of a physician would be practicing medicine. The nurse would be liable to arrest under such charge and the company held liable for malpractice in every case treated. The member was advised not to issue the prescription and the matter was immediately reported to the State Board of Health.

HIGH DEATH RATE

Dr. John E. Monger, Director of the Ohio State Board of Health, reports that the death rate for physicians runs about 17.22 per 1,000 as against 11.9 for all classes, including infants. Heart disease, declares Dr. Monger, makes up 22 per cent of the causes of mortality and pneumonia 9 per cent.

SAVES MONEY

Physicians of Wisconsin were saved upwards of $5,000 during 1926 as result of the single permit law passed by the State Medical Society at the 1925 session of the legislature. Permits issued physicians to prescribe, use alcohol for sterilization purposes or for compounding medicines, or to obtain liquor for emergency use totaled 1,578 during 1926. The 1926 income to the state was thus $16,040 as compared with upwards of $21,000 in 1925.

EVERY MEMBER PAID

Dr. J. C. Wright, Secretary of the Langlade County Medical Society, was again first to report a 100 per cent paid membership for 1927. He was closely followed by Dr. C. A. Armstrong, Secretary of the Crawford County Society, and Dr. H. C. Johnson, Secretary of the Rusk County Society. Official count showed a membership of 2,072 for the year 1926, the largest increase in a given year for many years back.

"A JOLLY GOOD FELLOW"

Dr. Charles S. ("Charlie") Sheldon, Madison, for twenty-five years Secretary of the State Medical Society of Wisconsin and now its Secretary Emeritus, celebrated his 85th birthday in January. Besides actively practicing his profession, "Charlie" is president of the local Yale Alumni Association, director of a bank, director of a trust company, a member of the Wisconsin Congregational Club and resident counsellor of the University of Wisconsin chapter of the Alpha Delta Phi fraternity.

Which reminds the Secretary of the last afternoon of the 85th Anniversary Meeting at Madison. The Secretary was just about ready to find a bed, anticipating a two-day nap when along came "Charlie" who had attended every session, early and late.

"George," said he, "This has been a wonderful meeting. I feel ten years younger."

"SIGNS OF LIFE"

An advertiser brightened up a day for us in January when he wrote, "It cannot be denied. Your Journal shows some signs of life, putting it mildly. It has much more life than many journals for which we pay much more for advertising."

BUSINESS EXPENSE

Declaring that expenses incurred by physicians in attending scientific meetings and post-graduate courses were actually "business expense" and that physicians should be allowed to make deductions in such amount on their state income tax returns, the Secretary appealed to the Chairman of the State Tax Commission for relief. While it is doubtful whether the Tax Commission will permit of change in their rulings the effort is being made so as to ascertain whether they would oppose legislative relief.

It was pointed out that the time has come when attendance at scientific meetings and post-graduate courses is a necessity rather than a luxury; that the physician voluntarily relinquishes his income during such period, and that should any additional income accrue it would

be subject to the regular income tax in subsequent years. It was further pointed out that the real beneficiary is the public and that physicians should be encouraged to take such trips rather than discouraged.

DENTISTS PLACE REPRESENTATIVE

During January the Chairman of the Legislative Committee of the State Dental Association asked the State Medical Society if it had objection to their having one dentist on the State Board of Health. When taken up with the Board that body invited the Dental Association to have a representative present at each of its future meetings to advise the Board.

RELIEF NOT PROBABLE

Members of the Milwaukee Academy of Medicine, owners of the Medical Arts Building in Milwaukee in which the State Society has its offices, finds itself faced with a $3,100 tax bill. They ask if this cannot be avoided by reason of the fact that the Academy is a scientific organization.

Individual members have been advised by the State Society that so long as the Academy leases a portion of its building to commercial organizations it may not claim exemption.

An interesting point was raised when a member asked if the Secretary would prepare a bill to exempt the property by legislative action. It was pointed out that all tax legislation must be by classes of people or property and that it was never possible to introduce a tax measure affecting any given person, corporation or piece of property.

AN INTERESTING QUESTION

A member interested in the development of periodic examinations of the apparently healthy persons has asked the Secretary a question that may take months of investigation to properly answer. The member states that it is well known that there exist certain corporations who offer health service by advertising. The applicant pays $25 and is then referred to a home physician for a partial examination, the physician receiving about $5. The physician's report is sent to the company office and the layman is then advised of his condition from such office.

The Secretary is now asked these questions:

1. Should not such a corporation be licensed to do business in Wisconsin?

2. If so licensed would they not be "treating the sick" in violation of Wisconsin statutes?

3. Is it possible that the physician is in fact "Splitting Fees" and would thus entirely unaware, open himself to a criminal action including forfeiture of his license?

Pending a legal investigation no answer can be given to these questions. Affirmative actions would be far reaching in their effect.

LENROOT WINS

The long congressional battle over whether the Sheppard-Towner maternity and infant welfare act shall be continued for another two years from June 30, 1927, to June 30. 1929, is over. Senator Lenroot, Wisconsin, champion of the bill, won his fight against Senator Reed who was determined to fillibuster the bill out of existence. After Senator Reed had three times postponed a vote Senator Lenroot outwitted him on the floor during January. Lenroot introduced an amendment declaring that the aid should not be granted after 1929 or in any way renewed. The amendment was adopted and the bill passed. Proponents of the measure rightly declare that the amendment was no concession inasmuch as one Congress cannot bind a succeeding one and that the amendment is valueless except as it secured passage of the measure. The bill now goes back to the House where it originated to have the amendment adopted.

PRESIDENT FRANK'S PRAYER

President Glenn Frank of the University of Wisconsin was educated to become a minister of the gospel. When the State Senate opened its first session it was President Frank who was called upon to offer the prayer. Because of its simple sincerity we print it here.

Almighty God, Lord of all Governments, help us, in the opening hours of this legislative session, to realize the sanctity of politics.

Help us to know that the call to office that has brought us here is nothing less than a call to cooperation with Thee in the wise direction of life in this commonwealth.

Give us the insight and grant us the power to lift this business of Government into an adventure that we may with reverence call the politics of God, because by it we shall seek to fashion the life of this commonwealth in the likeness of that City of God which has been the dream of saints and seers for unnumbered centuries.

Save us from the sins to which we shall be subtly tempted as the calls of parties and the cries of interests beat upon this seat of government.

Save us from thinking about the next election when we should be thinking about the next generation.

Save us from dealing in personalities when we should be dealing in principles.

Save us from thinking too much about the vote of majorities when we should be thinking about the virtue of measures.

Save us, in crucial hours of debate, from saying the things that will take when we should be saying the things that are true.

Save us from indulging in catch-words when we should be searching for facts.

Save us from making party an end in itself when we should be making it a means to an end.

We do not ask mere protection from these temptations that will surround us in these legislative halls; we ask also for an even finer insight into the meaning of government that we may be better servants of the men and women who have committed the government of this commonwealth into our hands.

Help us to realize that the unborn are part of our constituency, although they have no vote at the polls.

May we have greater reverence for the truth than for the past. Help us to make party our servant rather than our master.

May we know that it profits us nothing to win elections if we lose our courage.

Help us to be independent alike of tyrannical majorities and tirading minorities when the truth abides in neither.

May sincerity inspire our motives and science inform our methods.

Help us to serve the crowd without flattering it and believe in it without bowing to its idolatries.

Almighty God, Lord of all Governments, to whom all hearts are open, and from whom no secrets are hid, may the words of our mouths, the meditations of our hearts, and the intent of our measures be acceptable in Thy sight.

May we come with clear minds, clean hands, and courageous hearts to the sacrament of public service.

May we be worthy of the high calling of government. Amen.

SOCIETY RECORDS

NEW MEMBERS

Chase, Estelle S., Fort Atkinson.
Lynch, Charles, 1601 Vliet St., Milwaukee.
Bachman, C., 625 Walnut St., Milwaukee.
Warschauer, Bruno, 486 Edgewood Ave., Milwaukee.
Bercey, J. E., 114 Grand Ave., Milwaukee.
Morrison, M., Westby.
Ries, T. O., Luck.
Eames, H. F., Egg Harbor.
Simpson, J. E., Sturgeon Bay.
Zellmer, C. E., Antigo.
McGill, J. W., 1202 Tower Ave., Superior.
Conway, Hugh P., Spring Valley.
Bassuener, Reynold O., 167 17th St., Milwaukee.
Helmes, L. O., 180 17th St., Milwaukee.
Dillman, Asa E., Steuben.
Dockry, L. E., Kewaunee.
Gute, E. B., 156 Carlisle Ave., Milwaukee.
Morhead, Dewey E., Oxford.
Oliver, L. H., Friendship.
Jones, Arthur W., Randolph.
Costello, W. H., Randolph.
Gunderson, A. A., La Crosse.
Nystrum, L. E., Medford.
Dawson, Charles N., Beloit Clinic, Beloit.
Edwards, W. C., Richland Center.
Reynolds, Bertha, Lone Rock.
Fortner, W. H., Bloomer.
Ochsner, Alton, Wisconsin General Hospital, Madison.
Sokol, Theodore, 58th St., Kenosha.
Reed, C. C., Appleton.
Archer, W. E., Dale.

CHANGES IN ADDRESS

Heyer, Oscar C., Reedsburg, to Muirdale Sanatorium, Wauwatosa.
Ehmer, J. W., Crivitz, to Mayville.
Lowe, John W., Taylor, to Merrillan.

Many Bills Affecting Medical Practice Introduced As Legislative Session Opens: Propose Single Secretary For All Boards

"We attach much importance to the conservation of natural resources, and spend large sums of money for that purpose, but we are prone to forget that the most important subject to be conserved is human life," declared Governor Fred R. Zimmerman in his message to the Wisconsin Legislature which formally opened its sessions in January.

Two bills affecting medical practice were waiting for the legislature when it convened. Both came from the interim committee on taxation which proposed:

No. 5A. To abolish special legal counsel for all state departments. At present the State Board of Medical Examiners may employ such special counsel with consent of the Governor. The bill proposes that the Attorney General's department shall do all legal work for all state departments. In the framing of the bill, however, the interim committee so worded the bill as to prohibit the Board of Medical Examiners from employing any assistants whatsoever. The State Society will propose an amendment to remedy this situation.

No. 6A. This bill proposes that the State Health Officer (Dr. C. A. Harper) shall be made the secretary for the following boards: Basic science, medical examiners, examiners in chiropractic, board of pharmacy, dental examiners and board of examiners in optometry. The bill also provides that all records and offices shall be held in the State Capitol.

Several other bills will be introduced by the middle of February after which time bills may only be introduced through committees. Among these will be a measure to bring to date the law chartering the State Medical Society and all county societies; a measure to revise and bring up to date certain provisions of the act governing the practice of medicine and surgery, a measure providing that lye and like caustic solutions shall be labeled as poison, and a measure to provide certain reforms in the commitment of the insane. Before the March issue of this Journal, members of the State Society will receive a bulletin advising them of all measures introduced by or through individual members which affect public health or medical practice.

Committees Appointed

Shortly after the legislature convened the following committee appointments were announced:

Senate Committee on Public Welfare: Senators W. L. Smith, Neillsville (Chairman); Walter H. Hunt, River Falls; John Englund, Wittenberg; Walter S. Goodland, Racine, and Howard Teasdale, Sparta.

Assembly Committee on Public Welfare: Assemblymen Henry A. Staab, Milwaukee (Chairman); Helen F. Thompson, Park Falls; Philip J. Zink, Beaver Dam; William Coleman, Milwaukee; D. J. Vincent, Genoa City; Joseph J. Huber, West Bend, and A. J. McDowell, M.D., Soldiers Grove.

Bills affecting public health or medical practice must be passed upon by these committees.

The Joint Committee on Finance will pass upon all measures dealing with financial questions. These will include proposals by the State Society that the salaries of state health officers be fixed by the State Board of Health rather than by law; that salaries of physicians in state employ be fixed by the Board of Control rather than by law; and a bill sponsored by the Board of Medical Examiners and endorsed by the State Society proposing an annual appropriation of $5,000 to permit the Board to employ continuously a full-time investigator for the purposes of law enforcement.

Members of the Joint Committee on Finance are: Senators W. A. Titus, Fond du Lac (Chairman); J. H. Carroll, Glidden; Herman Boldt, Sheboygan Falls; R. Bruce Johnson, Superior, and Alex C. Ruffing, Milwaukee. Assemblymen Henry Ellenbecker, Wausau (Chairman); John Gamper, Medford; Charles A. Beggs, Rice Lake; Thomas M. Duncan, Milwaukee; Gardner R. Withrow, La Crosse; Peter R. Ebbe, Marshfield; Edward F. Hilker, Racine; Frank Lawson, Walworth, and A. J. Baker of Mount Horeb.

Two other measures were introduced during the last week of January. Assemblyman (Dr.) A. J. McDowell, Soldiers Grove, introduced a bill to bring up to date the law chartering the State Medical Society. This law, not materially changed since its enactment in 1841, is obsolete in several sections. The bill proposes to strike these sections from the statutes and is endorsed by the State Society.

A second measure was introduced by Assemblyman George Hinckley, Milwaukee. This would make it optional instead of mandatory that in cases where a physician is convicted of a crime in the course of his professional work, his license be revoked. At present the law is mandatory upon the Judge. Assemblyman Hinckley proposes to make revocation optional and in cases where the Judge does revoke the license, to further permit the Judge to restore the license at some later date.

Layman Proposes to Sell Medical Service at Dollar a Month: Warned Service Would Probably Violate Wisconsin Laws

A "Medical Service Bureau" in each city of Wisconsin selling the services of a local physician at a dollar a month was the layman's dream probably dissolved as result of a warning that such a plan was both unethical and probably illegal. The inventor disclosed his objective to several physicians of the state whom he attempted to secure as his local representatives. It was through one such physician forwarding his letter to the State Medical Society that the effort became known and the warning issued.

The layman proposed to solicit patients for one physician in each city. Each member family would pay $1 a month which would entitle them to medical service (except hospitalization and operations) without further charge. The promoter offered fifty per cent of the amount collected to the physician, the promoter to retain the rest for his efforts.

In conference the warning was given that any such "Medical Service Bureau" would either violate the statutes covering "Treating the Sick," or else place the physician in a position where he would become criminally liable under the statute on the division of fees.

The proposal follows:

Milwaukee, Wisconsin
January 8th, 1927.

Dr. ....,
....., Wis.

Dear Sir:

I am arranging to develop a Medical Service Bureau in several cities the size of ..... and the plan may interest you, as it will give the Doctor selected to attend the calls of the Bureau possibly $100 to $300 monthly income for attending a possible 25 to 35 calls monthly.

Through the sale of Memberships costing $1.00 monthly the Bureau or Service will be organized. These memberships will be sold to homes of moderate circumstances or poorer families who seldom have a regular Doctor, who usually are worried over possible Doctor bills, and who are glad to have the matter covered in the future on a dollar-per-month basis. Membership in the Bureau entitles the holder to Doctor's service for one month, any time needed, but does not cover hospital cases or expenses, of course. We do not sell insurance in the sense of the word, but sell a Doctor's service and attention on that basis.

It is figured that not more than 5 or 6 calls will be necessary out of each 100 members any one month. We will allow the Doctor joining us one-half of all membership payments each month to attend these calls, or $50.00 monthly from each 100 members to cover a possible 5 to 6 calls monthly, which should be worth while

We do not intend that this membership will interfere with anyone, and it will be organized and operated in a legitimate manner, the members will be secured quietly and efficiently, and if you were to join in with us it should mean extra clientele and income for you that you probably would not have otherwise.

We attend to all details of the organization, secure the members and collect the monthly payments, after it is organized we continue to build it up to make it a permanent thing for all concerned, and your name need not be mentioned with it outside of the fact that you attend the calls of the members of the Bureau. The organization of the Bureau can be done in a few weeks' time.

The initial membership is secured through direct-by-mail and personal solicitation in which we specialize. It is handled in the field there and from our office, and if the membership is large enough we will maintain a regular representative there to be on the job at all times, otherwise we handle it direct from the office here. In all events we continue to build it up after once started year after year.

We expect a small amount of cooperation from the Doctor who agrees to attend the membership calls, as we are in fact building up extra clientele and income for him on a substantial and permanent basis. Considering that the securing of 400 to 500 members in the Bureau would mean an income of $200 to $250 monthly for this Doctor to cover a possible 20 to 35 calls monthly, a clientele and income that will continue on for many years if we continue to build it up, we feel that a small amount of cooperation should be given by the Doctor to help cover our initial promotion expense. We figure about $100 for each 100 members we expect to secure would be a proper basis, or $500 cooperation in a city like ..... where we expect to secure about 500 members altogether. This cooperation need not all be paid in at once, say $250 at the time and balance when at least 10 members have been secured to show that the membership and Bureau will materialize as we explain it. That should represent a small outlay for the extra business and income, even if only 100 members were secured, however we expect to secure from 400 to 500 members in your city in reasonable time.

Understand, please, that you will have nothing whatever to attend to in the organizing or operating of the Bureau outside of attending to the Member calls, and home treatment, and you get one-half of all membership payments every month as collected. We attend to everything else.

The idea is not new, this form of membership medical insurance or service as you know has been used by many companies who employed large numbers of men. Today different insurance is carried by different mills, etc., but ALL workers are not covered. There are many homes in your city that do not have any medical insurance to speak of, and these are the ones our medical service memberships will deal with. These people are glad to get the matter of possible Doctor bills in the future covered on a dollar per month basis, and members will be secured.

We are all ready to go ahead with the promotion in your city, as soon as we have located a reliable Doctor there who will agree to attend the Bureau calls on this basis, and is willing to give this small amount of cooperation to assist in the initial promotion expense. We are not approaching all physicians there at this time, and only you, and we will appreciate having your reply on the matter at your earliest convenience. Our business references will be provided upon request. Any suggestions you may have to offer on the matter of proper preparation of the Memberships of the Bureau there to fit local or personal conditions will be carefully considered. I am,

Respectfully,

(Signed) .....

PERSONAL

County Secretaries Hold First Annual Conference; President Rogers Outlines Two Main Objectives for Year's Work

With thirty secretaries and fourteen other officers present, the entire day of Saturday, January 8th, was given over to a program outlining the aims of the State Medical Society of Wisconsin and means of further improving and aiding the county medical societies of the state. This was the first formal secretaries' conference for upwards of ten years and while secretaries have held special luncheons during each annual meeting, this conference inaugurated a system of annual gatherings at which a full day could be devoted to a discussion of mutual problems.

"Our county organizations are not going to function unless the members who compose them are on hand, and they are not going to be on hand unless there is something to go for," declared President Arthur W. Rogers. "The programs for the county medical societies have been the bugbear of the society for a good many years past, but that is now ancient history. With the University of Wisconsin and Marquette University and a great many other agencies from which we may draw material, there is scarcely sufficient number of months in the year to give you time to fill out the programs that you really can have."

President Rogers urged a continuation of the discussion of periodic examination of the apparently healthy persons and asked that one meeting this year include that subject by demonstration.

"I feel that any question as to whether the public wants it has been answered; they do want it," said the President. "The greatest question and the one raised most frequently by the medical profession is: how are you going to do it? How are you going to put it over? There are so many ways, is my answer. Here is a bulletin of the State Board of Health and right on the front page in large letters are the words "Get Examined."

Glenn Frank, speaking here yesterday before 6,000 people, advised them to go to their doctor and be examined twice a year. We have the lay press and the wonderful work that our Society Press Service is doing in that respect. We have the lay journals. But I think the best way is by word of mouth from physician to patient. It should not be a difficult thing for the physician who has the confidence of his patient and the families wherein he works to explain this project to them without self interest. And I think in the final analysis that is the way it is going to be put over,—by the explanation of the physician to members of the families in which he is active."

Dr. Rogers declared that during the year a special committee would work with societies and officers in all parts of the state on the subject of nursing.

"I believe there is a solution for everything," he said "and I believe that the county medical societies would work to a useful purpose were they to appoint a committee to study this question during the year as it applies to their own communities and provide our State Secretary with a résumé of their findings."

On the subject of program material available to the societies, offers of assistance and material available were outlined by the State Secretary, Dr. R. C. Buerki of the Universty of Wisconsin, Dr. C. A. Harper of the State Board of Health, Dr. H. E. Dearholt of the Wisconsin Anti-Tuberculosis Association and Dr. Robert E. Flynn of the State Board of Medical Examiners. The following discussed the general subject of attendance and membership, outlining means used in their several counties: Drs. Ralph Sproule, Milwaukee county; G. K. Wooll, Rock county; H. M. Stang, Eau Claire and Associated counties; M. D. Bird, Marinette-Florence counties; D. L. Dawson, Barron-Polk-Washburn-Sawyer-Burnett counties; J. F. Wilkinson, Waukesha county; and R. H. Bitter, Winnebago county.

During the day the following also presented addresses: Dr. Robert McE. Schauffler, President Jackson County Medical Society, Kansas City, "Speaking for Public Health and Periodic Health Examinations"; Dr. J. J. McGovern, President-Elect, "The County Society and Legislation"; Dr. Rock Sleyster, Treasurer, "The Ginger Teas"; Dr. Oscar Lotz, Chairman of the Editorial Board, "Using the Wisconsin Medical Journal," and Dr. Robert E. Flynn, Secretary State Board of Medical Examiners, "Law Enforcement."

The conference was concluded with a theater party Saturday evening. Each Secretary will soon be furnished with a copy of the proceedings.

Those attending the conference included:

D. L. Dawson, Rice Lake.
W. C. Henske, Chippewa Falls.
H. E. Gillette, Pardeeville.
C. A. Armstrong, Prairie du Chien.
Hans H. Reese, Madison.
H. M. Stang, Eau Claire.
J. F. Mauermann, Monroe.
H. A. Schulz, Ripon.
A. C. Nickels, Watertown.
H. A. Binnie, Kenosha.
N. P. Anderson, La Crosse.
S. A. J. Ennis, Shullsburg.
M. P. Andrews, Manitowoc.
M. D. Bird, Marinette.
C. D. Neidhold, Appleton.
J. W. Prentice, Deer Park.
F. R. Krembs, Stevens Point.
J. D. Leahy, Park Falls.
Susan Jones, Racine.
H. E. Kasten, Beloit.
H. C. Johnson, Bruce.
C. E. Stubenvoll, Shawano.
G. J. Juckem, Sheboygan.
R. L. MacCormack, Whitehall.
Wm. H. Remer, Chaseburg.
T. P. Keenan, Walworth.
J. F. Wilkinson, Oconomowoc.
A. M. Christofferson, Waupaca.
R. H. Bitter, Oshkosh.
A. W. Rogers, Oconomowoc.
Edward Evans, La Crosse.
C. A. Harper, Madison.
H. E. Dearholt, Milwaukee.
Rock Sleyster, Wauwatosa.
R. C. Buerki, Madison.
J. J. McGovern, Milwaukee.
Oscar Lotz, Milwaukee.
Ralph Sproule, Milwaukee.
G. K. Wooll, Janesville.
Karl Doege, Marshfield.
Robert E. Flynn, La Crosse.
Robert McE. Schauffler, Kansas City, Mo.

American Medical Association Holds Medical Practice Acts Ineffective: Commends Basic Science Law

In a pamphlet entitled "The Ineffectiveness of Medical Practice Acts: Basic Science Acts as a Remedy," Dr. W. C. Woodward, Executive Secretary of the Bureau of Legal Medicine of the American Medical Association declared during January for the passage of Basic Science Acts.

"Laws regulating the practice of medicine are not accomplishing their purpose," declared Dr. Woodward. "They are intended to protect the public against incompetence, professional and otherwise, in the prevention, relief and cure of illness and injury; they have not done so. They tend to insure the competence of practitioners of medicine, but the good thus accomplished has been offset by the legalization and entrenchment of one cult after another, of inferior qualifications, whose adherents have taken the places of the incompetent medical practitioners of former days. The public is, therefore, probably not materially better off now than it was when our medical practice acts were first passed.

WISCONSIN FIRST

The Basic Science Act, now commended by the American Medical Association, was first passed in Wisconsin on June 11, 1925. The second state was Connecticut on June 30th of the same year. Similar acts are now pending in several states including Minnesota.

"The legalized cults—the sanipractor, naturopath and chiropractor—are a menace, or else the qualifications demanded of practitioners of medicine are unnecessarily rigid. The cultist, without such qualifications, may lawfully assume full responsibility for the life and health of every patient who applies to him for aid. The law limits him only in the methods to which he may resort for diagnosis and treatment, and leaves him free to diagnose all diseases and injuries and to treat all patients, with such limited means as are at his command. If a patient is suffering from an eruption and the chiropractor believes that he can be cured by manipulation of his spine the chiropractor may lawfully take charge of the case, even though the patient has smallpox. If a patient has acute appendicitis, the naturopath may resort to methods peculiar to his cult, leaving the patient to die because of the postponement of an operation or of no operation at all. The expectant mother, threatened with convulsions or antepartum hemorrhage, is exposed by law to the tender mercies of the groups of practitioners named above and of others, who need have no knowledge of methods of diagnosis and treatment other than those of their respective cults, and who are therefore ignorant of their own limitations. In most states, the legalized cults are the sole judges of the qualification of their own members.

Proposed Remedies

"The cults referred to—sanipractic, chiropractic and naturopathy—are, however, so firmly entrenched by law that it is impossible to protect the public against them by any direct attack. To forbid practice according to the dogmas of such cults would deprive a large number of men and women of their means of livelihood. Cult practitioners lack the premedical education necessary to enable them to enter medical schools to qualify for the nonsectarian practice of medicine. Probably few of them could afford to sacrifice four years or more to obtain the degree of doctor of medicine and licenses to practice medicine. Moreover the exclusion of cultists from practice would destroy the value of cult colleges and deprive the faculties of such colleges of their prestige and emoluments. It would be, therefore, an insuperable task to exclude cultists from the practice of the healing art according to their respective dogmas.

"It has been proposed that cultists of all kinds be absorbed into the body of nonsectarian medical practitioners; that the slate be wiped clean, and that we begin all over again in the hope of keeping dogma out of the practice of the healing art hereafter. Such a process of absorption might raise the standards of some of the honest and more intelligent cult practitioners, but it would certainly tend to degrade the resulting conglomerate mass of practitioners generally. Moreover, there is no reason to believe that if tomorrow every cultist were by law converted into a nominally nonsectarian practitioner, new cults would not spring up. Cults have gained their present proportions because of the possibilities they afford for evading the requirements of medical practice acts, quite as much as because of any sincere belief in the

dogmas around which they rally. So long as there are laws excluding some persons from the practice of the healing arts, the wits of dreamers and of crooks will be busy devising some new dogmas and organizing new cults whereby to evade such requirements. To give cultist practitioners such unearned privileges and dignity as would result from their absorption into the ranks of nonsectarian practitioners would merely produce repeated crops of cults and cultists and a repetition of the absorption process from time to time, indefinitely.

"If the abolition of the cults is impossible and the absorption of the cultist into the body of nonsectarian practitioners inexpedient, a middle ground must be sought. It seems to have been found in the "basic science acts," such as have been passed in Connecticut and Wisconsin.

Basic Science Acts

"Basic science acts recognize the existence of various cults and of the dogmas about which they have been organized. They recognize also, that nonsectarian practice and cult practice are based on fundamental sciences with which dogma has and can have nothing to do—such sciences, for instance, as anatomy, physiology, chemistry, bacteriology, and pathology. Basic science acts, therefore, ignore all dogma and fix for all practitioners a uniform minimum standard in the sciences named.

"To avoid prejudices of cultists against examinations by nonsectarian boards and the distrust of nonsectarian practitioners in the ability of the cultists to conduct adequate examinations even in the fundamental sciences, basic science laws provide that the board shall be made up of persons not engaged in the practice of the healing arts. They overcome existing differences in the standards of preprofessional education by allowing even high school graduates to be examined in the basic sciences. Persons who pass the examinations held by the basic science board are given certificates to show that fact. Such certificates, however, do not entitle them to practice in any way; they merely authorize their admittance, on the compliance with other necessary conditions, to examination by any one of the several professional examining boards the certificant may elect. Without a certificate no applicant can be examined professionally. However, the certificate alone does not entitle him to appear for examination before any professional board; each board may impose such further requirements as the laws of the state authorize. The medical examining board may require evidence of at least two years of college work, of four years of study in a medical college and of one year of hospital experience, before admitting the applicant to examination. The chiropractic examining board, however, may be satisfied to accept the certificate of the basic science board as evidence of adequate preprofessional education—graduation by a high school—and insist on evidence of a graduation by a chiropractic college after not less than eighteen months of study. Other boards are at liberty similarly to apply their own standards to applicants seeking licenses from them. Every board is at liberty to accept as adequate the examination given by the basic science board in the fundamental sciences or to reexamine the applicant on those sciences.

"The reasonableness and fairness of the plan outlined is obvious. It recognizes that a certain knowledge of anatomy, physiology, chemistry, bacteriology and pathology is at the basis of all diagnosis and treatment whatever. It recognizes that the possession of such knowledge by all practitioners is necessary for the safety of the public. It ignores all differences of opinion among practitioners as to methods of diagnosis and treatment and sets up a nonprofessional board, representing the public, to determine the fundamental fitness of all would-be practitioners. Such candidates as this nonsectarian board has determined to be fit, and no others, are permitted to appear before the professional examining boards. The professional boards retain their present function of determining the fitness of the applicant to practice the particular method of healing professed by him. The method comes as near as any plan that has yet been offered to establishing a single standard for all who practice the healing arts in those states having independent sectarian boards. How far it is applicable to states having mixed boards depends on the organization and methods of such boards."

SHALL NOT SPECIFY DRUGGISTS

In a decision from the internal revenue service of the treasury department announcement is made that physicians, when writing prescriptions for liquor on Form 1403 "shall not name therein the druggist or pharmacist who shall fill such prescription" but rather leave the space blank.

Annual Meeting of Council Authorizes Representation at Legislature: Endorses House of Delegates' Program for Year's Activities

That the Secretary of the State Medical Society of Wisconsin shall attend the legislative session to be of all possible service to members of the legislature, and through them to the people of the state, was the action of the Council at its annual meeting held in Milwaukee during January. The Council passed upon the announced program for the year authorizing all appropriations made at the last meeting of the House of Delegates. Minutes of the Council meeting follow:

MINUTES OF THE COUNCIL MEETING

University Club, Milwaukee, Saturday, January 8, 1927

The Council was called to order by the Chairman, Dr. Edward Evans, and the following were present: Councilors Rogers, Harper, Cunningham, Bock, Connell, Evans, Redelings, Smith, Stang, Dodd and Dearholt; President-Elect J. J. McGovern; Karl W. Doege, Speaker of the House of Delegates, and Secretary Crownhart. The following were also present during the course of the meeting: Dean C. R. Bardeen, Madison; Drs. Robert E. Flynn and J. Gurney Taylor, State Board of Medical Examiners; Dr. D. L. Dawson, Rice Lake, Committee on Public Policy; Dr. Oscar Lotz, Chairman, Editorial Board, and Dr. Carl Henry Davis, President Milwaukee Academy of Medicine.

1. The Secretary assumed the chair announcing that the first order of business was the election of the chairman. Moved by Dr. Bock, seconded by Dr. Smith, that Dr. Edward Evans, La Crosse, be reelected for the year 1927. Moved by Dr. Connell, seconded by Dr. Bock, that nominations be closed and that the Secretary be instructed to cast a unanimous ballot of the Council for Dr. Evans. Carried unanimously,

2. Chairman Evans presiding. Moved by Dr. Redelings, seconded by Dr. Dearholt, that Mr. George Crownhart be received as Secretary for the year 1927. Carried unanimously.

3. Moved by Dr. Dearholt, seconded by Dr. Redelings, that Dr. Rock Sleyster, Wauwatosa, be reelected as Treasurer for the year 1927. Carried unanimously. The Secretary announced Dr. Sleyster's inability to attend because of illness. The Secretary was instructed to transmit the cordial greetings of the Council to Dr. Sleyster together with flowers.

4. The Chairman announced that under the new constitution it was in order to elect the Committee on Auditing and Finance. By unanimous choice the following were selected: Drs. Dodd, Rogers and Harper.

5. Moved by Dr. Smith, seconded by Dr. Redelings, that the minutes of the previous meetings as published in the Wisconsin Medical Journal be and are approved. Carried unanimously.

6. The Secretary reported that the following proposal remained as unfinished business: "Shall the Treasurer and Secretary be empowered to remit the dues of a member upon recommendation of his county secretary, for reason of ill health causing the member financial hardships," After discussion it was moved by Dr. Dearholt, seconded by Dr. Harper, that the Treasurer and Secretary be so empowered. Carried unanimously.

7. The Secretary reported that it had been suggested that some reduction of dues should be effected for physicians but recently graduated. After discussion by Drs. Bock, Rogers, Redelings and Evans it was moved by Dr. Smith, seconded by Dr. Bock, that no such step be taken at this time. Unanimously carried.

8. The Secretary's report was presented and upon motion by Dr. Cunningham, seconded by Dr. Dodd, the report was accepted.

REPORT OF SECRETARY-MANAGING EDITOR

To the Members:

This report covers the work accomplished since the Annual Meeting, Sept. 20 to January first. Its purpose is to give the background and outline which is to come before the Council meeting.

Membership

On December 20th the 1926 membership of 2063 showed an increase of 63 over 1925, the largest gain yet reported. Increases are noted in all but the 6th, 9th and 11th districts. There were still 45 in arrears for 1926. From these, letters from the Secretary fail to bring response. These older members, acquainted with the Society's policies and aims, are the Society's greatest asset. It is hoped that the Councilors may assist in reducing this list materially.

Component Societies

In accordance with action by the House and Council a charter has been granted the combined Pierce-St. Croix County Medical Society. Your Secretary attended its organization meeting and believes that its success is assured.

Other societies visited are Second, Tenth and Eleventh Councilor District Meetings; Milwaukee Academy of Medicine and the Rock, Langlade and Jefferson County Societies.

Dues

Two suggestions are pending with reference to dues.

(1) From time to time there is reported to your Secretary the name of some member, for years in good standing, but presently about to drop because of the fact that illness, consequent retirement from practice, and increased expenses prevent him from paying dues longer. This was discussed at the last Council meeting. At this time it is suggested that the Secretary and Treasurer be granted authority to remit for one year the dues of any such member certified to be in such condition by the Secretary of the member's county society.

(2) It has been suggested that the Council should consider and work out a method by which the state society dues might be reduced for those who have just entered upon their professional career. Your Secretary asked for information and advice from the General Man-

ager and Secretary of the American Medical Association and in response Dr. West reports in part:

"Generally speaking I would hesitate to advocate a reduction of dues to the state society for any class. I think it may be well enough for the larger county societies to make it possible for young men to be taken into membership on a basis somewhat different from that on which the older and better established men are accepted. As a matter of fact, this is done in a number of the larger county societies, notably in Cleveland. My understanding is, however, that even in those places where the younger men are required to pay less than the older physicians must pay, the state dues are the same for each group. It may be rather difficult to say just where the preference to younger men should stop. It takes some men much longer to become established than it does others.

"In my judgment the State Medical Society of Wisconsin is certainly offering ten dollars worth of advantages to its members, whether they be young or old."

Special Printing

The Society at its Annual Meeting adopted a new constitution and by-laws. It seems advisable to your Secretary that these be printed in booklet form that copies may be furnished those who may need them from time to time. The type for this material is still standing from the Journal run and authority is requested to reprint 500 copies at an approximate cost of $40.

Elections

Under the new constitution a committee on Auditing and Finance is provided to consist of three members of the Council itself. The committee should be chosen at this meeting. The Council also elects for the year 1927 a Secretary and a Treasurer.

Budget

A budget of probable expense for the calendar year 1927 will be submitted by the Treasurer, Dr. Rock Sleyster.

Two items of capital expense are suggested by the Secretary. (1) Additional storage room is required in which may be stored records of the Society, extra Journals and like material. The Medical Arts Building has given the Society all available shelf space. It is found, however, that a partition may be so raised as to allow room for many additional shelfs. The estimated cost is $170. (2) When the Society office was moved to its present quarters it was necessary to purchase furniture in the sum of about $400. Because of this expenditure, no purchase was made of rugs. It is estimated that both offices may be covered with a good grade of rug for approximately $150. This is not an urgent request and may be postponed for future action if that is the Council's desire.

Legislation

At the annual meeting the House of Delegates instructed the Committee on Public Policy to discuss in conference with the Wisconsin Manufacturers Association the feasibility of the bill proposed by the Committee on Lye Legislation of the American Medical Association. This bill in brief provides that such caustic solutions be labeled as "Poison" and two antidotes be listed. Mr. George F. Kull, Secretary of the Wisconsin Manufacturer's Association reponds that he "is of the opinion that the bill has much merit and for that reason will be glad to be of such assistance as we can in helping its passage."

This measure will accordingly be brought to the attention of the legislature.

The recommendations of the Society can then be briefly summarized as follows:

1. Endorsement of the Basic Science act without change.

2. Endorsement of a measure requested by the State Board of Medical Examiners making administrative changes in the law. This measure, discussed and slightly modified in conference, will provide in part that a physician convicted of a crime in the course of his professional conduct shall automatically lose his license; that licenses for itinerant physicians be abolished; and that the Board be granted additional funds for the purpose of law enforcement.

3. The Society will recommend a change in the laws chartering the Society. This change is purely administrative in detail.

4. The Society will recommend the above mentioned lye legislation.

5. The Society will suggest a measure relating to the commitment of the insane. In general this will make commitment of the paranoic type a bit easier; release for insane a bit more difficult, and will suggest that the physician's fee for determining insanity be raised from $4 to $10.

6. The Society will endorse any move to the end that salaries of physicians in state institutions be determined in the discretion of the State Board of Control rather than by statutes now obsolete.

Your Secretary has sent a little pamphlet outlining these recommendations to each member.

State Board of Medical Examiners

At this meeting of the Council there is pending a suggestion from the State Board of Medical Examiners that it would be of material help to them should the State Medical Society desire to assist the Board financially in its outlined campaign of law enforcement. At the time of the State Meeting the Council expressed disapproval of this proposal but your President, Chairman of the Council and Secretary felt that this might well go over to the January meeting that the question of public policy therein contained might receive the most serious and thoughtful consideration of the Council.

There is accordingly attached certain correspondence and material designed to acquaint the Councilors with that which has transpired since the Annual Meeting.

October 4, 1926.

To the State Board of Medical Examiners,

In Session,

Eau Claire, Wisconsin.

Gentlemen:

At the suggestion of your Secretary, Dr. Flynn, the House of Delegates of this Society formulated and adopted two complimentary resolutions, commending the Board for its proposed activities in the field of law enforcement and pledging the support of this Society.

Following the adoption of these resolutions Wednesday, September 15th, I had the pleasure of being called before the Board late Thursday afternoon, September 16th. At that time it was suggested that the Society might best cooperate in the following manner:

1. Affording the Board an extra stenographer, or the funds for an extra stenographer, for a period not to exceed three months; estimated cost $240-$300.

2. By urging upon all secretaries of the county medical societies the necessity of compiling the lists required by the Board and following this through until accomplishment.

3. Supporting in the legislature a bill to provide an appropriation of $10,000 a year to the Board for the purpose of better law enforcement.

4. Appropriating to the Board any sum up to the maximum of $2,500, which sum would be matched by the State Board of Medical Examiners, for the purpose of providing funds for law enforcement up to the time that the appropriation enumerated in (3) above would become available.

The House of Delegates, having held three sessions, had adjourned sine die at the time this request was placed before the Secretary. The Secretary accordingly placed the suggestions before the Council.

The Council desired to reaffirm its several offers of cooperation which are already in the Board's files and assures the Board that it will pursue diligently the matter of compilations of lists of practitioners desired by the Board.

The matter of an appropriation of $10,000 has been referred to the Committee on Public Policy and Legislation which will consider this prior to the legislative session.

In the matter of appropriations from the State Society funds, heretofore the Council has had no authority to make such original appropriations. Under the new constitution just adopted the Council now has such authority, but in order that the Councilors may thoroughly represent their constituents and consider all angles of the entirely new public policy such appropriations would entail, it is desired that additional time be granted the Council for this purpose. The Council will consider this as its first order at the annual meeting to be held during the first week or ten days in January next. In the interim the Council will appreciate any additional material, advice, and suggestions that the Board sees fit to offer relating to this question.

Most sincerely yours,

J. G. Crownhart, *Secretary.*

JGC:J

Wisconsin State Board of Medical Examiners
Office of the Secretary
La Crosse, Wis.
Nov. 26, 1926.

Mr. George Crownhart
153 Oneida St.,
Milwaukee, Wis.
Dear Mr. Crownhart:

For the past five months our board has been investigating illegal practitioners of medicine and osteopathy. We have been successful in locating some of the more notorious quacks and charlatans, who are continually exploiting the public and hope to have their case disposed of very shortly.

At present we are interested in clearing up Milwaukee, as your city harbors some of the worst charlatans in the State. You will realize our purpose is not one of medical persecution but, purely a public health measure, directed entirely in the interest of the general public, who are innocently being continually fleeced by these infamous cancer fakers, social disease manipulators, chronic disease specialists, etc.

We are not attempting a general reform (to check the numberless small offenders would be almost an endless task) but we do want these nefarious medical profiteers, abortionists, advertising specialists, unlicensed foreigners, etc., stopped.

We believe you will be interested in cooperating with us. We know your Council would aid us materially. For that reason, we have called a special meeting of our board at Hotel Pfister at 10:00 A. M. on Friday, December 3rd at which time we desire to draft some plan which will effectively combat these existing evils.

May we have the pleasure of your attendance at this meeting?

Respectfully yours,
State Board of Medical Examiners.
(Signed) Robert E. Flynn,
Per: Robt. E. Flynn, M.D., Sec.

REF:EH

Dec. 2, 1926.

The Committee on Law Enforcement,
State Board of Medical Examiners,
In Session, Hotel Pfister,
Milwaukee, Wisconsin.
Dear Drs. Rodecker, Flynn, and Taylor:

Officers of the State Medical Society in receipt of your kind invitation to participate in a semi-public meeting to be held at Hotel Pfister, December third, desire me to thank you.

We understand that at this meeting you will make an effort to formulate official plans for the enforcement of those public health laws which specify fundamental and basic requirements for those who hold themselves out as capable of treating the sick. We fully appreciate the importance of the problem of how proper enforcement of such laws, designed to protect the public, may best be secured. We also appreciate that the state and county officers, charged with the duty of such enforcement, may accomplish most with the moral support of a public fully awake to the menace to public health which exists when quackery is permitted to thrive.

The State Medical Society of Wisconsin has ever been aware of the extreme importance of this subject and has long endorsed every official movement designed to give the people in fact, the minimum of protection that is guaranteed each citizen by law. As you know, as recent as our last annual meeting, our House of Delegates adopted two resolutions commending the Board for its outlined activity in the field of law enforcement and

assuring the Board of such support as we might properly provide.

In accordance with your requests our Committee on Public Policy is now framing such amendments to the laws pertaining to the licensing of physicians as have been requested by you. This measure, when approved by you, as to wording, will have our active support.

As you have requested, officers of our component societies have been urged to furnish you with a list of all practitioners in their respective society borders. You now have such lists from all but fifteen of the fifty-one county societies and this office is working to the end that the remaining lists may be in your hands before January first.

In addition, we have reported such gross violations of the law, together with available evidence, as have come to our attention.

Your last request, one for funds, is under advisement and will be discussed at a Council meeting to be held on January ninth.

All this we have done at your suggestion, not only willingly but gladly, feeling that furnishing of such information as has been requested, was our responsibility and duty.

In the field of law enforcement as well as the field of law enactment, however, this Society has adopted a general policy designed to be in the best interest of the public and the profession alike. This policy, several times reaffirmed by the House of Delegates, asserts our belief that the organized profession of the state is not responsible for either the enactment or enforcement of public health measures. Rather that the responsibility of the profession is to provide accurate information from the viewpoint of medical science to those officially charged with the duty of law enactment and enforcement that such officials may have the best available information to assist and guide them in discharging the responsibility they have assumed.

The officers of the Society feel that this policy has many times proved its worth and that they would only defeat the public interest should they allow their enthusiasm for a proper law enforcement program to lead them into a field of work neither morally or legally theirs and for which activity the entire profession might be justly criticized. We are confident that you appreciate the dangers of any over-zealous activity of this Society which might permit those whom you may arrest to make the sentimental plea that they were being "persecuted by a medical trust" rather than prosecuted for gross violation of laws designed to protect the individual and public health.

We have accordingly reached the decision that we can aid you and your official program to the greatest extent by, (1) completing the lists you have requested, and (2) accomplishing such other efforts as you may request and which efforts fall within our domain of responsibility.

The officers are confident that you will fully understand this position and appreciate that we are withdrawing our support not one iota but rather reaffirming it; that we are intensely interested in your present program; and that we do not attend your meeting only for the reason that past experience has taught this Society that the most unselfish attempts to accomplish unofficial work in official fields only defeats the praiseworthy objects in view.

As Secretary of the Society I trust you will call upon us for any additional work, no matter how difficult, the accomplishment of which will be but a discharge of our responsibilities and an aid to you in your official efforts.

Most sincerely yours,

George Crownhart

December 6, 1926.

Dr. Robert E. Flynn, Secy.,
State Board of Medical Examiners,
State Bank Building,
La Crosse, Wisconisn.

Dear Doctor Flynn:

Just a note to advise you that for the fifteen county societies still outstanding, we have compiled in this office a complete list of their respective membership, giving the names in full. These have been mailed to the respective secretaries, asking them to add to such lists the names of all others in the county. Post cards were enclosed that we might check in this office on their mailing and I am already advised that the lists for Crawford county and Waupaca county have been forwarded. I think that the thirteen lists remaining will be in your hands promptly. If, however, by December 15th you still have one or more counties to hear from, I wish you would drop me a line to the end that I may complete this work for you by the first of the year.

I wonder if I ever told you that some months ago we sent a personal letter to each district attorney in the state, extending to him a year's subscription to Hygeia. Renewals will be sent out each Christmas, at which time we will also send a personal letter again. We have the feeling that an understanding of the basic health problems would go far to interest these enforcement officers in the field of health work.

If there are any other lists you desire or any counties where you feel that the lists are too incomplete to be of service, or if there is any other work that this Society may do for you at this time, please advise me.

Sincerely yours,

JGC:J J. G. Crownhart, *Secretary.*

"Not Quackery, But Quacks

"The secretary of the state board of medical examiners announces a statewide drive on quackery. In counties that have large cities, such as Milwaukee, the state and county authorities will be united in their effort. It sounds like business, and a long suffering public, which is compelled to put its trust, even the keeping of lives, into the hands of the medical profession with the knowledge that there is a good deal of fraud and deception masquerading under the name, will wish the campaign success.

"Also, the public will wait to be shown. We have heard the cry, 'Drive out old Doc Quack', so often. A few of his representatives have been brought to justice from time to time, but the old hypocrite has managed to do business just the same. And it is to be recalled

that, leaving aside the steady campaign carried on by some public health departments, most of the work has been done by laymen rather than by doctors.

"Now the official state body that is representative of all schools of medicine will act. How much real, honest-to-goodness help will it draw from the medical societies that are representative of private practice? There is a sticking point. For the state board in its campaign must inevitably come to the conclusion that greater than the menace of the organized quacks who flare forth with their pretensions is the harm done by men who, while still holding their good standing, are either incapable or dishonest. The public is being educated to avoid the claim-all cure-all quack. But it has little or no defense against the dishonest practitioner. Medical men know well enough of things that have gone on, and are going on, in their profession. Here is an opportunity for them to help.

"Radiologists, meeting in Milwaukee, sounded a battle cry to drive quackery out of their ranks. It is a splendid thing, fitting in with the movement that has been launched by the state board. Let every other branch of the healing profession help, as also the district attorneys, whose duty it is to prosecute. There has been all too much talk about driving out an abstract thing called quackery and not enough good work done to drive out individual quacks.

Editorial, Milwaukee Journal, Dec. 3. 1926.

Doctors on the Trail

To The Journal: I have just read your editorial, "Not Quackery, but Quacks," which appeared Dec. 6th and I hasten to express to you, as secretary of the state board of medical examiners, our appreciation of that article.

It expressed the very meat of the campaign we are now conducting.

For five months we have been quietly collecting evidence against all forms of medical quackery and we have now employed a special investigator, whose duty it will be to institute prosecutions in all cases where violations warrant.

Your statement, "How much real, honest-to-goodness help will it draw from the medical societies that are representatives of private practice?" hits the nail squarely on the head. This is the point our board has been constantly stressing on every occasion. We must have their co-operation—likewise the co-operation of every man, woman and child whose sense of honor and patriotism resents the terrific exploiting that these cancer fakers, criminal abortionists, cure-all profiteers and the like are making on the unsuspecting public.

Our board has no ax to grind—this is not a medical persecution—it is our sworn duty to enforce these medical laws and safeguard the public.

We have already received several splendid indorsements from various medical societies. We appreciate them very much but a little concerted action behind these beautifully phrased resolutions would aid us most materially.

Our present program of medical law enforcement is entirely directed to safeguarding the public.

We believe we are going to succeed and we will exert every effort to accomplish our goal.

The legal department of your county and the health department of your city have already responded nobly in this work and now, with the co-operation of your paper, we feel greatly encouraged.

I wish to express the appreciation of our board again for your splendid co-operation.

ROBERT E. FLYNN, M.D., *Secretary*,
Wisconsin State Board of Medical Examiners,
La Crosse, Wisconsin.

Milwaukee Journal, Dec. 19, 1926.

Periodic Health Examinations

At the time of the last Council Meeting, Dr. Harper indicated the willingness of the State Board of Health to publish a leaflet to the public on this subject. The proposed copy follows and it is suggested that each Councilor make suggestions and notations that Dr. Harper may have them at the time of this meeting.

PERIODICAL EXAMINATIONS OF APPARENTLY HEALTHY PERSONS

A reference is frequently made to the great likeness of the functioning of the human body to the functioning of a piece of machinery, such as an automobile. Both are subject to wear and tear through time and usage. The care which either gets during a lifetime is likely to determine the comparative age that they may be attained. It is by remedying small and beginning defects that greater injuries are avoided. This comparison between machinery and the human body is quite apt and understandable to most of us. In the case of the human kind we have come to a stage in our civilization where our medical knowledge plainly shows us that many maladies may be successfully cared for in their early stages with the avoidance of greater injuries to follow.

A physical examination once or twice a year is now considered of marked value for the purpose of pointing out to the individual his defects or adverse symptoms with the hopes that they may be limited by timely change of habit or diet, or such medical measures as the case may require. A review of the mortality statistics of recent years shows that these examinations are now more necessary than ever before because a certain class of diseases are increasing in prevalence and these diseases are for the most part of a chronic order. The following tabulation was compiled from the Census Reports of the U. S. Bureau of Commerce and represents the prevalence of the diseases herein named in the original registration states of 1900 and their prevalence in 1920 in the same states:

DEATHS PER 100,000 POPULATION
U. S. Registration Area

Name of Disease	1900	1920
Organic Heart Disease	108.7	158.0
Diabetes	10.4	18.7
Apoplexy and Cerebral Softening	71.4	85.4
Cancer	60.7	87.8
Acute and Chronic Nephritis	82.9	86.7

The tabulation for the last disease is given verbatim although there are indications that the acute form of kidney trouble is declining in prevalence and the chronic form increasing.

IN WISCONSIN

During the last fourteen years it has been found that deaths from cancer have increased 42%, deaths from nephritis (kidney disease) increased 12% and deaths from heart disease increased 49%. Deaths from diabetes have nearly doubled. Deaths from apoplexy and cerebral softening have greatly increased.

REASONS FOR INCREASE

In looking for reasons for the increase in these particular diseases we now have recourse to other statistics. The Census Bureau Reports of 1920 contain the statement that in 1900 the average age at death in the registration area of the United States was 36.5 years, but by 1910 this age had increased to 40 years, and by 1920 to 43.5 years. At the present date there are indications that the average age has advanced still further. These figures are inclusive of the deaths of infants.

The cause of this increase in longevity is largely due to a decrease in certain preventable diseases such as typhoid fever, where the deaths have been reduced 94%, diphtheria reduced 58% in the fourteen years, or nearly 90% since the advent of antitoxin. Meningitis has been reduced about 73%, scarlet fever reduced slightly over 25%, tuberculosis reduced about 42%, whooping cough about 42%, and deaths of infants under one year of age have been reduced about 46%.

The sanitation of our homes and work shops, the purification of our water supplies, safeguarding of milk and other food materials, and the great advance in medical and surgical methods have likewise combined to lengthen life with the result that more individuals than ever before are passing on through middle life to advanced years. As fortunate as this situation is, it carries with it a toll of maladies incident to later age and middle life such as are indicated in the tabulation given. This class of disease is usually manifested by slow and insidious beginnings, often times not sufficient to disturb the patient. Years of life may be added by the timely discovery of these ills and the rectification of their causes. Success in the treatment of cancer may follow the discovery of tumors in their incipiency or by the removal of benign growths which often break down into cancer in later age.

There has been no period in the world's history when so many men have been engaged in industrial life as today, or when so many men in middle life or past middle life are keeping at work in their employment, and the situation is now such that a man may be at his best, as employer or employee, until late in life, and it is his particular duty to see that no physical handicap should hamper him. With our newer knowledge, new methods are developed, and in the consideration of the increase of the chronic illnessess of middle life, the periodical physical examination should be looked upon as a means to their prevention and alleviation.

AGE FOR PERIODICAL PHYSICAL EXAMINATIONS

We have indicated the necessity of these examinations by the middle aged men and women of today. As a matter of fact, the periodical physical examination should be a necessity for every person regardless of age. It is well known to most of us that the examination of school children for defects has resulted in great improvement in the general health of the school children at large.

Tuberculosis, heart disease and other defects of young adults are usually insidious in their development. It is by the discovery of ailments in their early stages that measures for their cure can be taken with success. All flesh is heir to some ills. The discovery of them early in their progress is a chief factor in preventing their further extension. Excessive overweight and undue underweight should be given careful and frequent attention, and the man of normal weight needs an annual safeguarding.

EXAMINATION SHOULD BE THOROUGH

These physical examinations should be very thorough. A cursory examination by a physician is often of little value to the patient. A thorough examination should be made including all necessary tests to aid in determining the actual condition of the patient.

There are certain old elms standing in public squares in some of our eastern communities. They have outlived all their fellows. Their defects have long been kept remedied by caretakers. They still stand sturdy with passing of years. There is an analogy in their existence to the care of the human body. They point the way to individuals to take example thereby in the hopes of meeting to full extent, the years to which they are entitled. The best known solution of the chronic disease problem is an inventory of the body functions by a periodic examination of the apparently healthy person.

See your family physician.

"An ounce of prevention is worth a pound of cure."

Further Proposals

Your President, Dr. Rogers, will suggest the feasibility of holding a one day session on the conduct of periodic health examinations in Milwaukee. The purpose would be to interest some 20 or 30 men in this subject who reside in all parts of the state. These men would then be available to give demonstrations before contiguous county meetings.

Your Secretary has ascertained that for a sum of approximately $250 the Society might again send a special letter on this subject to each member enclosing 20 blanks prepared by the American Medical Association for the actual conduct of a periodical physical examination.

It has been suggested by the Treasurer that possibly the State Board of Health at its January meeting might be willing to authorize the printing and distribution of posters on this subject— most important in the field of disease prevention.

Revocation of Permits

From time to time your Secretary receives word from members who feel aggrieved that their permit to prescribe has been revoked. One such letter has come to his attention recently. Mr. E. C. Yellowly of the Eastern District advises your Secretary that the permits of 44 physicians have been revoked Sept. 1, 1925—December 1, 1926. It has been suggested that the society might

authorize legal counsel to attend a given number of revocation hearings in the future to determine and report whether, in his judgment, the government was giving full justice to the physicians arraigned.

Lay Education

Your Secretary has accomplished the following in this field of work:

1. By personal correspondence we have added a large number of weekly papers to our press service so that the service now embraces 45 daily papers and 225 weekly papers in the state.

2. By personal letters, Hygeia for 1927 has been presented to each member of the incoming legislature, our representatives in Congress, state officers, normal school libraries, the district attorneys of the state, and certain prominent and interested laymen.

3. The lay issue will be published as a supplement to the March or April issue and preliminary plans are now being formulated.

4. A special pamphlet to all members on the subject of legislation affecting public health has been prepared and distributed.

Miscellaneous

At this meeting the Council will set the date for the 86th Annual Meeting to be held at Eau Claire.

The Conference of Secretaries of County Societies is held the day prior to the Council meeting. All Councilors should attend if possible.

Cordially and sincerely yours,

GEORGE CROWNHART, *Secretary.*

9. In the absence of the Treasurer the Secretary reported the proposed budget for the calendar year 1927.

BUDGET, 1927

Membership in 1926 was 2069. Dues for 1927 are $10 and estimated income is $20,000 based on a 2,000 anticipated membership. The membership will probably be between 2,050 and 2,100.

	1926	1927	
Office—			
Rent	$ 600	$ 600	
Supplies, light, phone, postage, etc.	900	900	
Travel, Secretary	900	900	
Salary, Secretary (1)	4.400	4,400	
Salary, Miss Jurgens (2)	1.320	1,440	
Salary, Miss Ripley (3)	1.225	1.350	
		$9,590	$ 9,590
Lay Education—			
Hygeia	500	500	
Press Service	2.200	2,500	
Lay Issue	800	1,000	
		$4,000	4,000
General—			
Wisconsin Medical Journal	2,700	1,500	
Annual Meeting	500	500	
A. M. A. Delegate and Sec'y	400	400	
Delegate, Ia.-Minn.-Mich.-Ill.		200	
Comm. on Public Policy		2,000	
Secretaries' Conference		550	
Crusader	300	300	
		$5,450	5,450
Suggested Items of Additional Expense—			
1. Additional shelfing for storage room		170	
2. Rugs for office		150	
3. P. H. E. conference to teach demonstrations		100	
4. Printing Constitution and By-Laws		40	
		$ 460	460
			$19,500

The Journal is run on an entirely separate and independent financial basis, paying itself for the approximate time it takes to edit.

At the end of 1926 there was a surplus of approximately $17,000 in the general fund. Only a minor increase was made during 1926. Interest earnings during 1927 will be from $800 to $1,000. This has not been included in the estimated income. The Treasurer believes we should save this during 1927. All membership receipts above $20,000 will, of course, represent a saving but we cannot safely count on over 2,000 members in figuring the budget.

STATEMENT OF CONDITION
WISCONSIN MEDICAL JOURNAL
As of December 31, 1926

Net Assets December 31, 1925	$ 1,881.81
Receipts from advertising and subscriptions, 1926	12,868.87
Gain, P. & L. Account	80.70
Receipts, State Society, $1.25 per member	2,578.25
	$17,409.63
Publication cost (Printing, mailing, salaries, cuts, etc.), 1926	14,496.56
Net Assets, December 31, 1926	$ 2,913.07
Gain During 1926	$ 1,031.26

NOTE—During 1926 advertising was so increased as to reduce the cost of publication to the Society to $135.64 per month or a total of $1,627.28 for the year. This indicates a savings of approximately $4,000 per year over 1922 despite an increased circulation and a Journal more than twice the volume. For the year 1927 it appears that the cost of publication to the

	1926	Per Mo.	1927	Per Mo.
1. J. G. C. receives $1,200 from Journal—Total salary	$5,600	$466.66	$5,600	$466.66
2. Miss Jurgens receives $540 from Journal—Total salary	1,860	155.00	1,980	165.00
3. Miss Ripley receives $60 from Journal—Total salary	1,284	107.00	1,410	117.50

Society will be but $1,500 or $0.75 per member; the lowest in the history of the Journal.

J. G. Crownhart,
Managing Editor.

Moved by Dr. Redelings, seconded by Dr. Smith, that Item 2 of additional expense be granted. Carried unanimously. Moved by Dr. Smith, seconded by Dr. Stang, that Item 1 of additional expense be granted. Carried unanimously. Moved by Dr. Cunningham, seconded by Dr. Harper, that Item 3 of additional expense be granted. Carried unanimously. Moved by Dr. Redelings, seconded by Dr. Rogers, that Item 4 be amended to read $100 or more as may be necessary to print 3,000 copies of the constitution and by-laws together with the code of ethics of the American Medical Association and to distribute same to membership. Carried unanimously.

Moved by Dr. Redelings, seconded by Dr. Stang, that items of expense under the heading of "Office Expense" be approved with the amendment that salary of Secretary be changed to read $4.800 instead of $4,400. Carried unanimously. Moved by Dr. Smith, seconded by Dr. Redelings, that items under the head of "Lay Education" be approved. Carried unanimously. Moved by Dr. Cunningham, seconded by Dr. Harper, that items of expense under "General" be approved. Carried unanimously. After discussion, it was moved by Dr. Bock, seconded by Dr. Stang, that it be declared the policy of the Council that legitimate traveling expenses of state officers in the course of their work be included in the office item "Travel Expenses Secretary." Carried.

10. Discussion followed on the legislative policy of the society. The Council reaffirmed the position of the House of Delegates and authorized the Secretary to attend the legislative session as the agent of the society to the end that members of the legislature might be furnished with accurate information on legislation affecting public health and that Mr. Crownhart offer such service that the society at large might serve the state officials and through them the people of the state. The President was directed to forward a letter to members of the legislature explaining the policy of the society and offering Mr. Crownhart's services. Moved by Dr. Cunningham, seconded by Dr. Smith, that the foregoing be approved. Carried unanimously.

11. Dean Bardeen suggested that an amendment be introduced to the Medical Practice Act to the end that licentiates of the National Board of Medical Examiners be admitted to Wisconsin through reciprocity. Following discussion it was moved by Dr. Dearholt, seconded by Dr. Dodd, that this proposal be placed in the hands of the Committee on Public Policy and be presented to the legislature at the discretion of that committee.

12. After discussion it was moved by Dr. Cunningham, seconded by Dr. Redelings, that the next annual meeting of the State Society to be held at Eau Claire, be held on Tuesday, September 20th, (House of Delegates), Wednesday, September 21st, Thursday, September 22nd, and Friday, September 23rd (general sessions). Carried unanimously.

13. It was moved by Dr. Rogers, seconded by Dr. Stang, that the Secretary be clothed with full authority to make necessary financial arrangements for the reservation of all available hotel facilities. Carried unanimously.

14. The Council discussed that portion of the Secretary's report referring to revocation of permits of the Volstead Act and the Harrison Narcotic Act. After discussion by members of the Council and Dr. Flynn, Secretary of the State Board of Medical Examiners, it was moved by Dr. Connell, seconded by Dr. Redelings, that the Council take no action at this time. Carried unanimously.

The Council took a recess for lunch at 12.10. At the conclusion of the lunch, President Rogers presented the retiring president, Dr. Joseph F. Smith, of Wausau, with the gavel he had used during the 85th Anniversary meeting, as a memento of his presidential year. A silver band had been placed around the gavel upon which was engraved the record of Dr. Smith's service to the society.

15. The Council reassembled at 1:15 and Chairman Evans announced that the next order of business was the question "Shall the Society appropriate funds to the State Board of Medical Examiners for the purposes of law enforcement?"

(Secretary's Note—Because of the importance of this subject the Secretary incorporated into the minutes a summary of each discussion under this head.)

The Secretary stated that at the last annual meeting the House of Delegates had adopted two resolutions commending the Board of Examiners for its announced campaign in the enforcement of those laws pertaining to quacks and quackery; that the House of Delegates had instructed the officers and the proper committee to render all proper cooperation to the Board of Medical Examiners. The Secretary explained that the Chairman of the Committee on Public Policy not being present, the Secretary was invited to a Board meeting on Thursday afternoon, September 16th, (during the annual meeting) and at that time had inquired from the Board in what way or ways the Society might be helpful to the Board of Examiners. Several ways were pointed out, all subsequently adopted and accomplished, and in addition to these the Board had mentioned possible cooperation to the extent that the Society might appropriate any sum of money up to $2,500 to which sum the Board would add a like amount, such monies to be used for law enforcement.

"The House of Delegates having adjourned sine die," said Secretary Crownhart, "this question was referred to the Council meeting called by the Chairman at the conclusion of President Frank's address Thursday evening. At that meeting the sentiment was not favorable to the suggestion but the Chairman of the Council, with the President of the Society, the Secretary and the Treasurer, felt that the subject was of such importance as to warrant further investigation and consideration. The question has accordingly been held open for Council action at this time."

President Rogers then stated that this question had been uppermost in his mind during the past three

months and that more recently he had stated the principle envolved, without bias or prejudice, to the firm of Quarles, Spence and Quarles, Milwaukee attorneys. President Rogers added that as result of this statement of fact, he had received the following letter from the firm which he felt should be read at this time:

QUARLES, SPENCE & QUARLES
Attorneys & Counsellors
490 Broadway
Milwaukee

January 6, 1927.

Wisconsin State Medical Society,
153 Oneida Street,
Milwaukee, Wisconsin.
Dear Sir:

You have requested our opinion upon the propriety of a donation by your Society of monies to a certain State Department, said monies to be used by said department specifically for aid in the enforcement of a particular law, which we understand involves criminal penalties.

After an examination of the Constitution of the state of Wisconsin and the Statutes of the state, we have been unable to find any particular rule of law which makes such donation absolutely illegal.

However, it is probable that such a contribution by your Society would be considered to be against the public policy of the state, for the reason that public officers in enforcing the criminal laws are expected to do so out of public funds, in order that they will not feel hampered in any way by the source from which such funds came.

We feel further that your organization might become subject to severe criticism for making such a contribution. You will recall the criticism which was levied against a certain Senator of the United States when he proposed to offer his private fortune for the employment of a prosecuting attorney and clothed with senatorial powers to investigate a certain Federal Government. The criticism levied against that proposition was so severe that the offer was withdrawn, was never acted upon, and later money was appropriated for this purpose.

You will further recall the severe criticism recently registered in the public press against an organization in Pennsylvania which had contributed funds to the state to aid in the enforcement of the prohibition laws.

We can see no substantial difference between the situation which you have presented to us and the above two situations, and we believe your organization might be subjected to the same criticism as the individual and the organization above noted were subjected to.

Upon an investigation of the Supreme Court cases in the state of Wisconsin, we find that it has been held in this state to be against the public policy of the state to allow a private person to employ and pay counsel to assist the district attorney in the prosecution of crime. We believe that the reasoning of the Supreme Court in this case applies very closely to your situation.

In the case of *Rock vs. Ekern*, 162 Wis. 291, the court said at page 295, after discussing prior adjudications, that

"These adjudications clearly establish that employment and payment of private counsel to assist the district attorney in the prosecution of persons for crime by private parties is against the public policy of the state."

We find further in the case of *Bienel vs. The State*, 71 Wis. 444, that our court stated:

"We think it is quite clear from the reading of our Statutes on the subject, as well as upon public policy, that an attorney employed and paid by private parties should not be permitted either by the courts or by the prosecuting attorney to assist in the trial of such criminal cases."

It appears to us that the reasoning in these cases is applicable to your case, and that although we do not believe it is specifically illegal for you to make a donation specified, yet we are of the opinion that you may be laying yourselves open to severe criticism on the grounds of public policy, and if your contribution was questioned in the courts, it is not at all improbable that our Supreme Court would follow the reasoning of Rock vs. Ekern, above set forth, and hold that private contributions to be used in the enforcement of a specific criminal act were against public policy, and therefore could not be made.

We trust that the above opinion is clear to you and covers the points requested by you in our conference of the other day.

Very truly yours,
QUARLES, SPENCE & QUARLES,
By L. J. Burlingame

39—ABM

The Chairman then announced that the Secretary of the State Board of Medical Examiners was present and he would call upon him for a statement at this time.

Dr. R. E. Flynn told the Board that while the law made it mandatory for the Board to enforce the sections of the act entitled "Treating the Sick" the compensation was so inadequate that the efforts had largely been labors of love. He stated that the Board had made every effort to raise the standards of requirements and that while it was not particularly interested in the minor violations, it was intensely interested in the gross cases such as the cancer fakers. Dr. Flynn said he was surprised to note the large number of people in the state who were profiteering upon the sick and that the profession owed it to themselves, not as physicians, but as good citizens, to see that the public had some measure of protection from those posing as licensed physicians.

He further stated that the Board had recently employed a trained full-time investigator and that the Board had planned to publish a pamphlet explaining the aims of the Board, which pamphlet might be sent to every physician in the state. He declared that 90 per cent of the complaints now came from the profession and that as a result of such publication he felt more complaints would be received.

Dr. Flynn pointed out that this work necessitated

a full-time investigator clothed with legal authority if juries were not to be led into acquittals by the claim that quacks were being persecuted rather than prosecuted. He said that the Board had no desire to inveigle any medical man into court work; that such work was a proper field for the full-time investigator, but that the Board needed the cooperation to inspire proper officials to more speedy action.

"During the Secretaries' Conference," said Dr. Flynn, "Dr. McGovern, in talking on legislation, said that the Board had asked to have the law changed so that it would read the Board '*may* institute prosecutions' instead of reading as it now does, '*shall* institute prosecutions.'

"Dr. McGovern was mistaken in making this statement for we only asked for this change so far as it refers to the employment of counsel, who, in our experience, eats up our funds without adequate results.

"The funds of the Board on hand fluctuate considerably. It generally runs from $5,000 to $7,000 at any given time but it has been less this year because the board has held three special meetings to discuss the problems of law enforcement and in addition we have sent our osteopathic member to the osteopathic convention which convention pledged us any assistance they could render.

"We want legal counsel but the real assistance that we need now must come from the district attorneys. Our greatest trouble in the field of law enforcement has been the expense envolved. I am not here to beg money from fellow members of the State Medical Society of Wisconsin. Our Board has accumulated evidence, however, of flagrant violations of the law and we feel that if we may make a start and get a few into court we will get financial aid from the legislature later on. Now we need money to start the ball rolling. If we do employ an investigator we must pay him in the neighborhood of $300 a month and his railroad expenses and give him fair assurance of at least a year's work. The one now on trial is a failure but we can get the right kind of man if we can give him fair assurance of steady employment.

"If we employed a $300 a month man now we would be bankrupt at the end of the year. The Board will ask the legislature for an appropriation to carry on this law enforcement work and if we get it it will be magnificent, but our experience leads us to believe that the legislature is not inclined that way. If, however, we do get a legislative appropriation we would be glad to pay back this money to the State Society dollar for dollar.

"I would like to tell the Board on Tuesday next that we can go ahead. But if we cannot get the money from the State Society all our efforts to date will fall by the wayside."

Chairman Evans then announced that another member of the Board was present and called on Dr. J. Gurney Taylor of Milwaukee.

"The problem of law enforcement is difficult at its best," declared Dr. Taylor. "The quacks very often have the best of legal advice and have ample funds with which to combat legal actions. Recently the Milwaukee Journal carried a full page advertisement of a company advertising a special truss as a remedy for ruptures. An investigator noted that the company would have its 'Dr. Perkins' in Milwaukee on a given date and went to the address stated. There the company representative referred him to 'Dr. Perkins' for examination. As result he was informed that he needed a truss and went down stairs and purchased one from the company for $9.00.

"Immediately thereafter a second deputy with a detective went to the building and asked to be directed to the physician who had examined this man, stating that he was a city employee and they desired to ascertain his condition. The company representative informed the deputy and detective that 'Dr. Perkins' was upstairs. When the deputy and detective were ushered into the doctor's office, the detective immediately recognized the doctor known as 'Dr. Perkins' as being a Milwaukee physician whose real name was of course not 'Dr. Perkins'.

"Upon interview with the attorney," continued Dr. Taylor, "we were advised that 'you doctors have funny ideas.'

"You will see that our problems of law enforcement are hard propositions. The quacks secure the best possible legal advice and it must be plain that necessity exists for a capable investigator. While a short, quick investigation will scare some out, the Board really should have a full-time man to make continuous effort in this field of public health protection. For this we need funds and the Board fund is limited.

"I believe, however, that the public is beginning to realize the problem. We had a meeting here in December at which was present the city health commissioner and assistant district attorney, and representative members of the profession together with reporters from the press. At that time the assistant district attorney said that in the prosecution of quacks the medical profession must be kept out; that these efforts should be accomplished solely through proper enforcement officers, for the question of the profession itself entering into prosecutions always raises the question if it is not persecution rather than prosecution."

Dr. Dawson of the Committee on Public Policy stated that he recognized the difficulties envolved and cited the Till case where three court actions were necessary before a jail sentence resulted.

Dr. McGovern discussed the quackery situation as it exists in Milwaukee. He urged physicians to become a power in the community, that as influential citizens they might bring this public health queston into the prominence that it deserved in community life.

Dr. Smith asked what an investigator could do.

Dr. McGovern responded that even though the district attorney were willing to prosecute cases, he was not willing to secure evidence nor to sign warrants and that this was the field for the investigator.

Dr. Connell asked the question whether or not the Society, by such a grant of funds, would not place itself in a position where it could not deny similar requests for funds from other state departments.

Dr. Dearholt declared his feeling that the appropriation of funds for law enforcement by the State Society was to his mind a very questionable policy. He declared himself willing to appropriate monies to set the needs clearly before the legislature but did not feel that it was proper for the society to appropriate monies directly.

Dr. Flynn stated that unless money was forthcoming from some source the Board could not do the work.

"If we have to wait for the legislature," said Dr. Flynn, "the chances are that nothing will be accomplished and the Board will drop the program at the Tuesday meeting."

Dr. Harper pointed out that the Interim Committee of the Legislature had proposed a change in the law authorizing the attorney general's office to assist district attorneys in all criminal cases in the lower courts as well as the supreme court. He realized that difficulties existed in securing prosecutions of quacks. He stated that at the present time they knew of an unqualified person who was treating a case of venereal disease in a communicable stage and that three physicians had examined the patient and certified to the fact that the disease was in a communicable stage but that while appeal had been made to a district attorney, no warrant had as yet been issued.

Dr. Flynn stated that complaints were pouring into his office.

"Members of medical societies can not understand," said Dr. Flynn, "why something isn't done. We can't do much, however, by correspondence. We must get the evidence direct and then the law states that the complaint and warrant must be signed in the county where the alleged violation is occurring. The Secretary of the State Board of Medical Examiners, much as he might like to, can not sign warrants in La Crosse county. We know that at least eight or ten unlicensed physicians are now practicing and have charges in our possession against others, but we must have an investigator to accomplish results."

There being no further discussion, Dr. Evans asked for a motion. It was moved by Dr. Cunningham and seconded by Dr. Connell, that the Society adhering to its announced law enactment and enforcement policy, several times reaffirmed in the House of Delegates, assured the Board of its cooperation in every proper way; that the Council pledges its support to the legislative program of the Board, including a bill to obtain funds for law enforcement, but that it is the sentiment of the Council that it does not consider the direct appropriation of monies to the State Board of Medical Examiners to be used for the purposes of law enforcement, as a proper function of the State Medical Society of Wisconsin. The motion was put and without further discussion, carried unanimously.

16. The Secretary announced that the President of the Milwaukee Academy of Medicine, Dr. C. H. Davis, had asked for the cooperation of the Council in establishing a series of short post-graduate courses to be given in Milwaukee by lecture and by demonstration during the summer of 1927. It was moved by Dr. Bock, seconded by Dr. Smith, that the Chairman of the Council appoint a committee to assist in this effort, such committee to consist of three members of the Council. Carried. Chairman Evans announced the appointment of President Rogers, as chairman, and as the other two members, Dr. Bock and Dr. Doege.

17. The Council discussed with Dr. Harper the matter of lay education for periodic health examination movement and was pledged the utmost cooperation of the Board of Health in this public health movement.

18. The Secretary presented to the Council newspaper clippings from a state paper in which the column on "local news" was filled with sentences such as "Mr. John Jones is a patient at ——— Hospital." The Council directed the Secretary to correspond with the hospital named and to present this question to the two hospital associations in Wisconsin to the end that all possible cooperation be extended to the Society in its enforcement of the code of medical ethics.

19. The Secretary presented to the Council the fact that prior to January, 1926, an applicant for reciprocity from Wisconsin to another state had to pay a $2.00 fee to the Wisconsin Board for the certification of his credentials; that since January, 1926, the Board had raised such fee from $2.00 to $10.00. The Secretary stated that this had just been called to his attention by a member who asked if the fee were not exorbitant. The Council directed the Secretary to write the Board of Medical Examiners to ascertain the reasons prompting the raising of the fee and to re-present this question at the next Council meeting.

There being no further business before the Council, it was moved by Dr. Rogers, seconded by Dr. Bock, that the Council adjourn. Adjournment was taken at 4:45 p. m.

J. G. Crownhart, *Secretary.*

Approved: Edward Evans,
Chairman of the Council.

State Board of Health Formally Endorses State Society Press Service: Authorizes Introduction of Bill For County Health Officers

Declaring that the State Medical Society of Wisconsin is accomplishing far-reaching results in the education of the laity in the fields of medical science and the prevention of disease, the State Board of Health formally endorsed the press service of the Society at the January meeting, held in Madison on January 20th. In offering the motion, Dr. Windesheim pointed out that this weekly service was now reaching upwards of 300 newspapers in Wisconsin each week.

The Board also endorsed a proposal that a bill be introduced to authorize county boards to appro-

priate funds for the employment of county health officers and the organization of county health departments. The bill will further provide that such officers are to be either appointed from a list presented by the State Board of Health, or that such appointments are subject to approval by the State Board.

Other actions of the Board follow:

1. Adopted a resolution to be presented to the legislature calling for an increase in the appropriation for the Department of Vital Statistics from $51,000 per year to $70,000.

2. Authorized introduction of a measure to remove the present $3,000 limit on the salaries of deputy state health officers.

3. Authorized a bill to repeal a law requiring that the consent of the State Board of Health must be obtained to legally disinter dead bodies.

4. Received a representative of the State Dental Association and invited the Association to continue such representation that the Board might be advised on health matters relating to oral hygiene, with expenses incurred to be paid by the Board.

5. Voted to recommend for adoption by local government units in Wisconsin the socalled uniform milk ordinance as promulgated by the U. S. Public Health Service in its weekly report of July 30, 1926.

6. Passed resolutions relative to the deaths of Drs. William F. Whyte, Leonard E. Spencer, and Harry B. Sears.

7. Amended Rule 17 relating to the sanitary care of schools to add the following provision: "In cases where parents neglect or refuse to provide children who have scabies with immediate and proper treatment until the ailment is cured as determined by the entire disappearance of the eruption, it shall be the duty of the health officers of the town, village or city where the family resides to immediately placard said home until such time as the disease is no longer communicable."

8. Re-elected Dr. Otho Fiedler, Sheboygan, president of the Board, and Dr. Joseph Dean, Madison, vice-president of the Board.

Wisconsin Blue Sky Laws Aim to Prevent Fraud; Cannot Guarantee Against Loss,—"Investigate Before You Invest"

BY MISS OLGA M. STEIG
Examiner, Securities Division, Wisconsin Railroad Commission

This is the third of a series of articles written especially for this Journal. We believe these articles are not only of interest but of the greatest value to our readers.—Editor's Note.

The classification of securities into two groups, Class A and Class B, is a creation of the legislature, and one which the legislature alone has the power to change. The application of the standards thus created, however, is the administrative function of the Railroad Commission.

Class A securities, as I explained in a previous article, are those which meet certain minimum standards fixed by the act; in the Class A group there will inevitably be those which meet the standards with no margin to spare, and others whose earnings or property values go far beyond what the law requires.

A much wider range will be found in Class B securities than in Class A, for they include everything from the highly speculative stock of a new and untried venture to the security which, by the narrowest margin, falls short of Class A standards. It must not be assumed that all Class B securities are highly speculative and undesirable. The weakest of them must be sold as speculative securities it is true, but in the Class B group there are many reasonably good issues, and perhaps occasionally a very good issue which, only because of the inflexibility of Class A standards, is entitled to only a Class B permit.

The first problem of the Commission, then, in giving consideration to an application for permit, is to ascertain whether the standards for Class A securities have been met. But that is only a part of the problem, for every application involves three broad factors which, it may fairly be construed, the legislature must have believed were germane to the question of fraud. Irrespective of other considerations, the Commission must be satisfied:

(1) That the proposed plan of business of the issuer is not unlawful, unjust, unfair, or inequitable.

(2) That the commissions to be paid for the sale of the securities are not unreasonable.

(3) That the securities it proposes to sell, and

the methods to be used in the sale thereof, are not such as will work a fraud on the purchaser.

Quite naturally as to Class A securities these factors do not often give rise to serious question. In some instances, to be sure, because of exorbitant commissions or because of an obvious fraud in the financial plan, the Commission has refused to permit the sale of securities, notwithstanding the fact that they have conformed to Class A standards. But such instances have been relatively few, and it is largely with Class B securities that the factors become highly important, for here they are the only standards by which the issuance of a permit can be determined.

The extent to which the Commission, through the application of these broad standards, has been able to check the more common evils in corporate finance, offers, I think, the best evidence of its achievement in the administration of the blue sky law. The problem of palpable fraud and its suppression is relatively simple; but the brand of fraud represented by impracticable and ill-advised business ventures and by unfair financial set-ups and inequitable ratios in the distribution of profits is the big problem which the Wisconsin act, and others similar to it, seek to meet.

The evidence which the Commission demands is no more than the careful underwriter demands before he underwrites an issue, nor, indeed, more than the individual investor should demand before making a large investment in a single security. In the established enterprise, its financial history, the value of any properties pledged as security for a bond or note issue, and the purpose of the financing are factors of paramount importance. In the new venture, however, it is the plan of business, the personnel, the financial set-up, and the representations to be made in the sale of the securities that form the nucleus of the Commission's inquiry. As to those enterprises which fall between the two extremes, the relative importance of the factors varies with the nature of the business and the extent of its operations.

It is surprising to be asked every now and then why the Commission allows the sale of stock in a venture which it must know cannot succeed. Obviously it does not permit the sale of securities in a venture which it *knows* cannot operate successfully. It would hardly be so foolish as to allow the sale of stock of a company promoting a perpetual motion device or a group of opium chain stores. The first is clearly impracticable and would serve no useful purpose. The second would be in violation of the law of the land and could not long survive.

But between what one *knows* cannot succeed and what one believes cannot succeed there is a vast difference. If an applicant presents a plan of business that is not unlawful, unjust, unfair or inequitable, if the commissions it proposes to pay for the sale of the securities are not excessive, and if, in short, the securities are not inherently such as would work a fraud on the purchaser, the Commission cannot refuse a permit, notwithstanding its own conviction that the enterprise will not operate successfully.

A recent oil promotion in a community in central Wisconsin is a case in point. Water in a number of wells had been reported unfit for use because of the presence of an oily substance similar to the oil found in near-by bogs and marshes. To a geologist, to whom traces of oil in swamp lands occasion no surprise, this evidence was of no importance, but to lay residents of the community, whose imagination had been fired by the oratory of a practical oil man with years of experience in Oklahoma and Texas oil fields, it was evidence of "the substance of things hoped for." To them, exodus from poverty into the promised land of oil and wealth seemed imminent. These residents knew that the state geological survey had made a careful examination of that particular locality and had reported that in its opinion neither oil nor ore could be found in commercial quantities. It had been explained to them that traces of oil could be found in most of the swamps in the country, but that these traces could not be construed as evidence of oil in commercial quantities. Notwithstanding this report, a number of persons who would be financially affected by the discovery of oil secured the services of a Montana geologist, who, after examining their properties, also reported adversely. But in spite of two adverse reports, a company was formed, leases covering a substantial acreage secured, and application for permit presented to the Commission.

They represented to the Commission that this was no stock selling scheme. The stock was to be sold only to property owners in the immediate vicinity, whose property would greatly enhance in value if oil were discovered. No commissions were to be paid for the sale of the stock. The pro-

ceeds were to be used only for the drilling of a test well.

They readily admitted that they had been advised, not only by the state geological survey, but by their own consulting geologist, to abandon plans for the drilling of a well. But there was just the chance, they argued, that all of these scientific men might be mistaken. They were going into the venture with their eyes open; they were ready to take the risk; they were ready to lose, if necessary.

The Commission was convinced that the enterprise could not be profitable. It had confidence in the report of its consulting petroleum geologist and respected his judgment. But human judgment is not infallible. Geologists themselves readily admit that their conclusions are not invariably right. Here was a plan of business that was not unjust, unlawful, unfair, or inequitable, and certainly no one could claim he had been defrauded if, at the time he bought stock, he had knowledge of the adverse reports of reputable geologists who had examined the properties. In view of all the special circumstances of the case, the Commission believed that its only function was to surround the sale of stock with such conditions that no one would have unfair advantage and no one would be deceived or misled; accordingly, it allowed the sale of enough stock to cover the cost of a test well, subject to substantially the following conditions: The stock was to be sold at par, only for United States money, and without payment of commissions; organization and promotion expenses were limited to $500; the sale was restricted to residents of four counties in which the oil "boom" had centered, for it was residents of these counties who had clamored for the right to speculate in the hope that land values might be enhanced; the cash proceeds from subscriptions were required to be deposited in the name of a trustee in a Wisconsin bank until such time as the company had obtained enough bona fide collectible subscriptions to assure completion of a test well, such proceeds to be returned and subscriptions cancelled providing the necessary capital could not be raised; and to give every investor adequate warning, subscription contracts were required to set forth the fact that reputable geologists had reported adversely on the properties. Fortunately, there is no dry hole to evidence the faith and failure of this "community enterprise," for the company failed to raise adequate capital to drill the well and the venture was finally abandoned.

The lure of large profits is by no means confined to oil and mining ventures. In fact, I question whether such ventures now rank first in the losses which investors sustain annually in highly speculative securities. The promotion of mechanical devices covers the whole field of inventive ingenuity, from hairpins to washing machines and from bottle caps to airplanes, and takes a tremendous toll from the investing public. It is only natural that during the last decade the profits of Ford, General Motors and other successful automobile manufacturers should have stimulated the organization of new automobile enterprises financed by public stock sales, few of which have attained any degree of financial success, and many of which have unfortunately turned out to be mere stock selling fiascos. The middlewest will not soon forget Pan Motors which probably stands out as the most flagrant of promotion schemes of the last ten or fifteen years. And the financial losses and actual financial distress occasioned by the many automobile accessory ventures and the truck and tractor promotions which have sprung up in the last few years as a natural outgrowth of the increasing popularity and utility of the motor, will remain a poignant memory for years to come. Yet these losses are only a small part of what might have been. The public will never know and can never appreciate the extent to which the Commission has circumvented possible losses by denying permits for the sale of stock in thoroughly impracticable or ill-advised enterprises.

Typical of the ill-advised ventures which a gullible public is asked to finance was a recent automobile venture on which the Commission refused a permit. A clever inventor had "perfected" a motor which he claimed had twice the power of any ordinary motor of similar size, notwithstanding the fact that the claim for increased power violated all accepted laws of leverage; a clever promotor was engaged to "put the thing across." Notwithstanding some amusement over the strange mixture of physics and metaphysics exhibited in a treatise by the inventor on the subject of leverage, the Commission gave careful thought to the merits claimed for the engine. Convinced that it was wholly impracticable, the Commission argued with the promoters that the

motor could not possess the efficiency and power which they claimed. But they countered with a challenge that they could prove it, not with drawings alone, but with the motor itself. They asked the privilege of a practical demonstration. Here, obviously, was a problem for the physicist and the mechanical engineer. Unable, because of inadequate facilities to experiment with the engine, the Commission made arrangements with the Engineering Department of the University for both laboratory and field tests, and for a careful mathematical analysis of the efficiency of the motor. The company was then advised that such arrangements had been made, and was asked to designate a date when a motor could be delivered. That ended the pressure for action on the application, and no protest was heard when the permit was denied.

More amusing, and certainly more puzzling, was the cemetery promotion a few years ago in which the Commission also refused a permit to sell stock. A cursory examination revealed no palpable fraud. There was no evidence of a promoter's profit in the transfer of the land. The commissions to be paid the promoters for selling the stock were reasonable enough. The financial set-up provided for an equitable distribution of profits. Certainly the plan of business was practicable—we still bury our dead. It seemed to bear all the characteristics of somber respectability, yet the Commission believed it to be a promotion scheme. The thought of exploiting human sympathies and personal misfortunes was abhorrent; it seemed unlikely that such an enterprise would be promoted except for a secret profit to the organizers and the Commission determined to find the source of that profit. A searching inquiry into the personnel provided the first clue. It was found that the promoters had organized similar enterprises in other cities and that their records were not altogether enviable. None of their ventures had operated successfully, but when asked about them, they furnished plausible explanations. The Commission could not refuse a permit merely because the personnel was not to its liking, nor because other ventures, similarly promoted, had not operated at a profit. Finally, the Commission demanded that plans for the landscaping of the cemetery grounds and schedules showing the cost of trees and shrubbery to be planted, be submitted. These the Commission turned over to an independent landscape architect with a request for an opinion as to the practicability and desirability of the plans and the reasonableness of the cost schedules. And here was the "joker!" The landscape architect reported that if all the trees and shrubbery included in the schedules were planted, they would have a veritable forest with no space left for graves!

While such factors as the exorbitant cost of capital, under-capitalization, over-capitalization, so-called watered stock, and unwise investment of funds during the promotion period are not essential elements in fraud, yet they may be the differential between success and failure in any enterprise. They are important problems to every investor and the extent to which the Commission has solved them is without question its most important constructive achievement in administering the securities act.

It would be interesting to analyze the operations of several thousand enterprises financed by the public and to ascertain what are their gravest errors. I suspect that a surprisingly large majority would be found to share at least one common error—the error of commencing operations before there is assurance of sufficient capital for the conduct of the business. This is particularly true of concerns which must invest substantial sums in fixed assets. Every stock salesman knows that the acquisition of a factory site and the immediate construction of the "first unit"—the stock salesman always stresses the "unit" plan—create high enthusiasm which is a primary requisite to every stock selling campaign. Drawings of proposed buildings and photographs showing the progress of construction help even the best sales talk; and more effective than elaborate sketches and photographic displays is the personally conducted tour through the factory building, during the course of which, even though the building may be far from completed, the prospect usually becomes an enthusiastic stockholder and booster. His enthusiasm blinds him; he does not realize that the construction of a factory and the investment of large sums in machinery and equipment, without positive assurance of adequate capital for the conduct of business, are steps which too often lead to financial disaster. Such steps may stimulate stock sales but they are bad business. Fond du Lac, Chippewa Falls, Eau Claire have had their tire and rubber enterprises, Green Bay, Kenosha, Appleton, Menasha, Port Washington their truck

and tractor ventures; Peshtigo its pulp and paper promotions—all financed by the sale of stock to the public, all of them with well-constructed, well-equipped factories built during the stock selling campaigns, and all of them forced, within the space of a few years, into reorganizations in which the stockholders had the choice of losing their entire original investment, or "protecting" it with additional funds—a sad choice for the man who has invested his life's savings and has no funds with which to "protect" the investment.

State regulation cannot, of course, guarantee sufficient working capital to any business enterprise, but it can, to some extent, prevent business failures resulting from the inability of a new enterprise to finance itself. If it is known that it will cost not less than $15,000 to drill an oil well to a given depth, it is wasteful to begin drilling with only $5,000 on hand and no assurance that the balance will be available when needed. Similarly, if a business enterprise needs $100,000 with which to engage in business, it is bad policy to commence the erection of a factory until there is reasonable assurance that the capital needed can be raised. Before issuing a permit to any new enterprise, therefore, the Commission demands evidence that the contemplated capital, if procured, will be sufficient for the conduct of the business. But that is not all. Cognizant of the temptation to dissipate assets during the promotion period, the Commission demands assurance that the proceeds from stock sales will be held intact until there is reasonable assurance that the venture will be adequately financed. In all new enterprises, therefore, the proceeds from stock sales, less actual selling expenses, are required to be deposited in a Wisconsin bank or trust company in the name of some responsible person as trustee for the subscribers, such funds not to be withdrawn, nor to be subject to the claims of creditors until sufficient subscriptions have been obtained and sufficient cash payments made thereon to offer reasonable evidence that the enterprise will be able to secure the necessary capital with which to operate. A reasonable period is allowed within which the capital must be obtained, but obviously, there must be a time limit at which the trustee must liquidate his account and either return to the subscribers the sums they have paid in, if it becomes apparent that adequate funds will not be available, or turn such funds over to the company for corporate purposes, if the conditions have been fully satisfied. The wisdom of this requirement is amply evidenced by the number of cases in which the proceeds have been returned to subscribers because of the failure of the enterprise to secure adequate capital.

The tendency to over-capitalize and to issue generous blocks of stock for assets of doubtful value has been a common evil in corporate finance. There is no economic basis for organizing a $50,000 business with a capital of ten or twenty times that amount. Yet that was a common practice in this state ten years ago. At that time almost every new enterprise, in which professional stock salesmen invited the public to invest, was organized for a million or so, and usually "a controlling interest" was issued for a patent or formula, and in some instances even for the experience of some person interested in its promotion. A patent or formula may have potential value to a new enterprise, but experience—a service to be rendered—wholly dependent on human capacity for whatever transitory value it may have, is not an asset which a new business ought to purchase for any substantial consideration. The Commission will allow the issuance of a reasonable block of stock for a patent or other intangible asset of *potential value,* subject, however, to the restriction that the consideration issued therefor is valueless to the person receiving it so long as the patent or other intangible asset is valueless to the corporation. Stock issued for intangibles must be placed in escrow subject to an agreement prohibiting the sale thereof until such time as the corporation has demonstrated its ability to earn a reasonable dividend on all stock outstanding, including, of course, the escrowed stock. In such cases, the stock retains all its usual rights and privileges, the only restriction being against its sale. But here again there must be a definite time limit and the agreement usually provides that if the conditions have not been fully satisfied within five years from the date thereof, the stock is to be returned to the corporation for cancellation without consideration. There have been very few instances in which the conditions have been fully satisfied!

The problem of the unfair or inequitable financial set-up is in some respects the most difficult

(Continued on Page XXIV.)

THE JOURNAL BOOK SHELF

The Ophthalmic Year Book. Volume XXII. Containing bibliographies, digests and indexes of the literature of ophthalmology for the year 1925. Edited by William H. Crisp. Published by the Ophthalmic Publishing Company, Chicago, September, 1926.

Medical Clinics of North America. Philadelphia number, September, 1926. Volume X, Number 11. Octavo of 217 pages with 16 illustrations. Per clinic year, July, 1926, to May, 1927. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

Acute Epidemic Encephalitis. (Lethargic Encephalitis) An investigation by the Association for Research in Nervous and Mental Diseases. Report of the papers and discussions at the meeting of the association; New York City, December 28th and 29th, 1920. Paul B. Hoeber, New York City.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared original articles on treatment, medicine, surgery, neurology, pediatrics, obstetrics, gynecology, orthopedics, pathology, dermatology, ophthalmology, otology, rhinology, laryngology, hygiene, and other topics of interest to students and practitioners. Volume III. Thirty-sixth series, 1926. J. B. Lippincott Company, Philadelphia and London.

The Duodenal Tube and Its Possibilities. By Max Einhorn, M.D., Prof. of Medicine at the New York Post-graduate Medical School; visiting physician to the Lenox Hill Hospital, New York. Second edition, revised and enlarged; illustrated, F. A. Davis Company, Philadelphia, 1926.

Essays in the History of Medicine. By Karl Sudhoff, M.D., translated by various hands and edited by Fielding H. Garrison, M.D., Lieutenant Colonel, Medical Corps, U. S. Army. Volume II of The Library of Medical History; $5.00 postpaid. Medical Life Press, New York, 1926.

Pathology of the Nervous System. By E. Farquhar Buzzard, M.D., physician to St. Thomas' Hospital and physician to outpatients at the National Hospital for the Paralyzed and Epileptic, and J. Godwin Greenfield, M.D., pathologist to the National Hospital for the Paralyzed and Epileptic. Paul B. Hoeber, New York City, 1925.

Modern Clinical Syphilology. By John H. Stokes, M.D., Prof. of Dermatology and Syphilology in the School of Medicine, University of Pennsylvania. Octavo of 1444 pages with 885 illustrations and text figures and more than 200 detailed case histories. Cloth, $12.00 net. W. B. Saunders Company, Philadelphia and London, 1926.

Life Insurance Medicine. A study of some of its problems and their relation to clinical medicine by members of the medical department of the New England Mutual Life Insurance Company. Volume I, published by New England Mutual Life Insurance Co., Boston, 1926.

Young's Practice of Urology. Based on a study of 12,500 cases. By Hugh H. Young, M.D., and David M. Davis, M.D., Johns Hopkins University, with the collaboration of Franklin P. Johnson. Two octavo volumes totaling 1,484 pages with 1,003 illustrations, 20 being color plates. Per set: Cloth, $25.00 net. W. B. Saunders Company, Philadelphia and London.

The Human Cerebrospinal Fluid. An investigation of the most recent advances, as reported by the Association for Research in Nervous and Mental Disease. The proceedings of the association; New York, December 29th and 30th, 1924. With 77 illustrations and 58 tables. Paul B. Hoeber, New York, 1926.

Report on Third International Congress of Military Medicine and Pharmacy. Paris, April, 1925. By Commander William Seaman Bainbridge, M.C., United States Naval Reserve Forces, Member of Permanent Committee, Delegate from the United States. Reprinted from The Military Surgeon, May to August, 1926, inclusive, Washington, D. C.

The Normal Child and How to Keep It Normal in Mind and Morals. Suggestions for parents, teachers and physicians; with a consideration of the influence of psychoanalysis. By B. Sachs, M.D., New York. Price $1.50 net. Paul B. Hoeber, Inc., Medical Publishers, New York City.

Diseases of Women. By Harry Sturgeon Crossen, M.D., Prof. of Clinical Gynecology, Washington University Medical School and Gynecologist in Chief to the Barnes Hospital and the Washington University Dispensary; Gynecologist to St. Luke's Hospital. Sixth edition, revised and enlarged, with 934 engravings, including one color plate. Price $11.00. C. V. Mosby Company, St. Louis, 1926.

Surgical Clinics of North America. Vol. VI, No. 4, Mayo Clinic Number, October, 1926. Pages, 274 with 91 illustrations. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

Medical Clinics of North America. Vol. X, No. 3, Mayo Clinic Number, November, 1926. Octavo of 275 pages with 55 illustrations. Per Clinic year, July, 1926, to May, 1927. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

BOOKS RECEIVED FOR REVIEW

Report of the Department of Health of the City of Chicago for the Years 1923, 1924 and 1925. By Herman N. Bundesen, M.D., Commissioner of Health, Chicago, 1926.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared original articles by leading members of the medical profession throughout the world. Volume IV, thirty-sixth series, 1926. J. B. Lippincott Company, Philadelphia and London, 1926.

Transfusion of Blood. By Henry M. Feinblatt, M.D., Asst. Clinical Professor of Medicine, The Long Island College Hospital, Brooklyn, N. Y. Illustrated by 24 engravings. The Macmillan Company, New York, 1926.

The Conquest of Disease. By Thurman B. Rice, M.D., Assistant Professor of Sanitary Science, Indiana University School of Medicine. The Macmillan Company, New York, 1927.

A Manual of Pharmacology and Its Application to Therapeutics and Toxicology. By Torald Sollmann,

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Kahn Dry Goods Store, Racine
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Luck's Shoe Store, Rhinelander
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M.D., Professor of Pharmacology and Materia Medica in the School of Medicine of Western Reserve University, Cleveland. Third edition, entirely reset. W. B. Saunders Company, Philadelphia and London.

The Specialties in General Practice. Compiled by Francis W. Palfrey, M.D., Instructor in Medicine at Harvard University in collaboration with 14 other teachers of Harvard Medical School. Octavo of 748 pages. Cloth, $6.50 net. W. B. Saunders Company, Philadelphia and London, 1927.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 153 Oneida Street, Milwaukee, Wisconsin. These new books will be loaned for an inspection period only.

Shell Shock and Its Aftermath. By Norman Fenton, Ph.D., Associate Prof. of Psychology, Ohio University. Illustrated. Price $3.00. C. V. Mosby Company, St. Louis, 1926.

This is an extremely well presented description of the psycho-neurotic problem, intensively studied, primarily at Base Hospital 117, with a follow-up on many of these cases one and six years afterward. One advance made in the handling of this problem was the intelligent manner in which these cases were treated in the front line ranks, with a large percentage of the acute cases returned to duty. Too much cannot be said for the intelligent organization, personnel, and follow-up work. It is estimated that forty thousand war neuroses were rejected in the cantonments. The most favorable cases to respond to treatment were those of concussion, anxiety, and gas, while the neurasthenic, psychasthenic, and hysterical type still remain the same problem as we have always met in civilian life. The old question still remains unanswered as to whether we can accept these cases as functional in origin. There has been no new light thrown upon this question, but the tendency is to base the sickness upon some psychological and physiological background.—W. T. K.

Practical Surgery of the Joseph Price Hospital. By James William Kennedy, M.D., Surgeon to the Joseph Price Hospital, Philadelphia; Consulting surgeon to the Norristown, Coatesville and Chambersburg Hospitals; formerly in charge of the Gynecological and Obstetrical Department of the Philadelphia Dispensary. Illustrated with 129 original half-tone plates, some in colors. Price $10.00 net. F. A. Davis Company, Philadelphia, 1926.

In this book Dr. Kennedy has attempted to immortalize Dr. Joseph Price. It is an accepted fact that Price was one of the greatest pioneer surgeons of America. However, it strikes one that it is entirely unnecessary to print some 800 pages to put across this idea and incidentally some of the principles taught by this great man. There is too much repetition and the personal pronoun "I" is used too frequently to make the treatise interesting reading. The text is too vague and indefinite to even be used for teaching purposes. It is also rather poorly arranged.

The chapter on Vaginal Hysterectomy is very worth while excepting that one cannot agree with the author on the treatment of cervical carcinoma or uterine prolapse, nor can one see any rationale for keeping patients in the hospital for a total of 27-30 days for the cure of prolapsus, cystocele and rectocele. The vaginal hysterectomy clamps which apparently are a great asset in performing this operation are neither described nor illustrated.

Practically all of Kennedy's opinions are based upon his memory and not on actual figures as they should be. It is peculiarly characteristic of human beings to forget errors in diagnosis and unsatisfactory end results.

Even today Dr. Kennedy does not believe in anything but gauze drainage. He uses nothing but non-absorbable sutures, irrigates the pelvic and abdominal cavities in frankly purulent cases, never uses the cautery for chronic inflammatory lesions of the cervix, removes gallbladder in only two per cent of patients when that organ is diseased, has never had a post-operative hemorrhage following abdominal hysterectomy, favors the Murphy button over any other method of anastomosis and finds that Caesarean section is the most satisfactory method of treating toxemias of pregnancy, placenta praevia and hyperemesis gravidarim. There have been no deaths from peritonitis and no broken down wounds from the high Caesarean section. He condemns the low and extra-peritoneal methods but does admit that this operation is being done too frequently.

The chapter on appendicitis, tubercular peritonitis, ectopic pregnancy, shock and neglected umbilical hernia are worthy reading.—R. S. C.

Transfusion of Blood. By Henry M. Feinblatt, M.D., Asst. Clinical Professor of Medicine, The Long Island College Hospital, Brooklyn, N. Y. Illustrated by 24 engravings. The Macmillan Company, New York, 1926.

An interesting historical résumé of the steps leading up to the modern practice of blood transfusion is given. This is followed by a discussion of blood groups; special emphasis being placed upon the need of direct compatibility tests as violent reactions have been known to occur when patient and donor were in the same group. The author enumerates the following as indications for blood transfusions. Sudden losses of blood from any cause; surgical shock; illuminating gas poisoning; chronic hemorrhagic diseases of the blood; as a preoperative precaution when the bleeding and clotting time has been found to be delayed; blood dyscrasies; subacute systemic bacterial infections; acute septic conditions; diabetic coma; debilitated conditions; and miscellaneous conditions. Several methods of performing transfusions, including that of the author, are given in detail.—M. C. P.

Nasal Accessory Sinuses. Pathology and treatment of the inflammatory diseases of the nasal accessory sinuses. By Prof. Dr. M. Hajek, Chief of the Laryngo-Otological Clinic, University of Vienna. Translated and edited by Joseph D. Heitger, M.D., Louisville, Ky., and French K. Hansel, M.D., St. Louis, Mo. Price $17.00.

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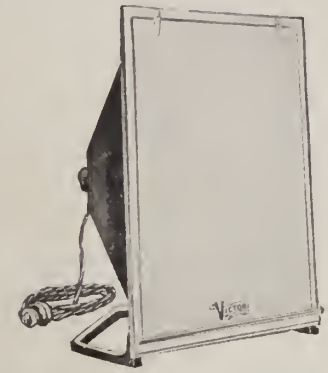

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Fifth edition, completely revised and enlarged. C. V. Mosby Company, St. Louis, 1926.

This work consists of two volumes; the first volume is divided into two parts, the first being general part which takes up first the normal anatomy and in this section it takes up the anatomy of all the bones that enter into paranasal sinuses anatomy. The anatomical descriptions are extremely clear and many illustrations are used to bring out the author's views of the relative anatomy.

Second. Normal anatomy of the maxillary sinus. Under this title the author devotes several pages to the antrum and is complete in detail.

Third. Normal anatomy of the frontal sinus. Under this topic he deals with the general anatomy as well as the relative anatomy of the frontal sinus. Normal anatomy of the ethmoidal labyrinth is given with its relation and comparative sizes in accordance with the author's research.

Fourth. Normal anatomy of the sphenoid sinus. As in all the other sections he takes up the general and relative anatomy very clearly and completely.

Fifth. The normal anatomy of the mucous membrane of the accessory sinus. He gives the blood and lymph supply of the normal lining and makes an effort to explain the physiology of the paranasal sinus, but the explanation is quite incomplete when compared with the rest of the work.

Section Two. Pathogenesis. Under this section he takes up the cause of para sinus infection, giving his bacteriological views, and in it all has apparently a very broad experience and a rather conservative idea of sinus infection.

Section Three. General pathological anatomy. Takes up the changes in the membranes of the sinus during disease but is quite short and limited. In many places it fails to give a clear picture of the pathological changes.

Section Four. Symptoms. This subject is extremely well covered and with a view apparently based upon broad experience and keen observation. There is nothing particularly new in this section.

Section Five. Diagnosis. Under this section he gives his views clearly, concisely as to arriving at a definite diagnosis as to paranasal sinus disease. He gives his method of entering all the sinuses and follows this with a very clear and rational section on therapy. Under the section of therapy the two principal ideas that he follows are first, the removal of the cause and second, free drainage. Medication is not spoken of.

Special Part. To this part he devotes 131 pages. The entire section is given over to the maxillary sinus. It is a very complete review of literature plus the author's own opinion. There is nothing in this section apparently new or that has not appeared in the literature previously.

Part three is devoted to five pages on x ray work of the paranasal sinus giving the positions best to show the paranasal sinuses.

Volume one has 130 illustrations, many of which are schematic, many anatomical drawings, and they are used frequently to demonstrate the author's thought.

Volume Two is covered by 345 pages and in reality is a continuation of the special part of Volume One.

Section One. Inflammation of the frontal sinus. 112 pages are devoted to this. In it the author gives the same careful detailed attention to the frontal sinus as he did to the antrum, and it is a review of the literature plus the author's own thought. There is nothing but what has appeared in previous publications that is new.

Section Two. Inflammation of the ethmoidal labyrinth.

Section Three. Inflammation of the sphenoid sinus. These are covered in the same careful manner as those of the previous sections have been covered, and it certainly is a very excellent review of all that has been done in these branches.

This is followed by 15 pages devoted to infections of the accessory sinus associated with ozina. He gives a very clear understanding of the changes of the tissue, but nothing new in the line of treatment.

Complications. Under this section I believe that the author has covered rather briefly the more important complications associated with parasinus disease, but unfortunately he has given very little of his own detailed experience in dealing with these complications. He sights numerous instances of complications published by other men, but it is very evident that these reports have been condensed down so materially that they carry but very little interest and give nothing of the details of laboratory findings or pathological reports. Under the section of therapy of complications it is more or less a general discussion of the possibilities of treatment rather than the giving of any definite technique and no doubt this is done to conserve the size of the volume.

Thirty-two pages are devoted to the list of references to literature and I believe this covers very well the credible work which has been done upon these subjects.

—J. S. G.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared original articles by leading members of the medical profession throughout the world. Volume IV, thirty-sixth series, 1926. J. B. Lippincott Company, Philadelphia and London, 1926.

This number of the well-known Clinics is made up mostly of the papers read during the trip of the International Post Graduate Assembly in Europe last year. There are sections on Diagnosis and Treatment, Medicine, Surgery, and an account of the Cleveland meeting of the 1926 Interstate Post Graduate Assemblies of North America by the editor, Dr. H. W. Cattell.

The articles are interesting and to those who took the trip would be especially valuable in complete book form. There are also other brief articles on Medicine and Surgery by men in this country. Some are of the form of Clinical Lectures and others as articles.

This volume is quite up to the standard of the "International Clinics" which for so many years have been of help to physicians throughout the country in their practice.—L. M. W.

Readings in Abnormal Psychology and Mental Hygiene. Edited by W. S. Taylor, Prof. of Psychology in Smith College, with an introduction by Joseph

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Biologic Considerations in the Handling of Disease*

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There is abundant evidence in medical discussion from the platform or in the journals that in the study of disease more and more thoughtful attention is being given fundamental biologic considerations. Attention is concentrated on the cell instead of on the tissue which it helps construct; on what is going on within that cell rather than on the changes in tissue structure; on physico-chemical activities in nucleus or cytoplasm rather than the reaction of tissues or the alteration of functioning in organs. This may properly be considered as a biologic interest, for biology is truly the knowledge of vital phenomena; and while that definition is comprehensive enough to give it the widest inclusion of all the allied branches of science, we instinctively feel that biology ultimately leads us to narrow our vision to the cell and to study the various actions and reactions within that unit. The condition of malformation of any organ or tissue, or a resultant structural abnormality; the pathologic changes in organs and tissues producing disease with its great variety of clinical manifestations—these phenomena, theoretically, if not always actually, may be resolved in the final analysis to physico-chemical changes within the cell.

For a long time, we have had our attention called to morphologic changes in cells: the various forms of cancer cells, the transition from one variety to another; the arrangement and form of cells in the tubercle; the changes in blood cells wrought by malaria or pernicious anemia—a dozen examples come readily to mind. Possibly the medical man of another generation will be able to list a dozen examples of the physico-chemical or electrical changes in cells under conditions of disease. Some of these changes have already been well enough defined to make them of important interest to the clinician; and it is certain that the present period of medical study and research will have a profound effect upon the handling of disease. Among those who have recently contributed notably to the study of these biologic considerations are E. McDonald[1, 3], B. Sherwood-Dunn[2], S. D. Ludlum[3], G. W. Crile[4], and F. C. Waite[5], from whose writings I shall quote freely.

Living matter as found in the cells of all human beings is made up of some combination of four elements, C, H, O, and N. They are albuminoid substances forming so-called colloidal complexes or particles, the constitution and ultimate structure of which is as yet unknown. These albuminous particles maintain themselves at a certain state of physico-chemical equilibrium by drawing from their surrounding medium the substances of which they are composed. Under normal conditions they assimilate what they need for nutrition and activity, and eliminate useless waste.

The biologic unit of living matter, the cell, consists of a certain number of these albuminous particles which diversify into at least three kinds of particles, those forming plasma, nucleus and membrane. They are immersed in a clear liquid composed of salts and crystalloids, the cells themselves being also immersed in a like fluid which in addition contains colloidal particles, the plasma, lymph, etc. The maintenance of the proper equilibrium of these cells in the human organism has three important factors in the selection of substances to be used in cellular nutrition:

First, the choice of food by the being himself;

Second, the selective action of the membranes of the digestive tract; allowing only the passage into the blood of certain substances which have been transformed into more simple compounds;

Third, the selective action of the cell membranes in absorbing certain substances and rejecting others which in turn must be eliminated by lungs, skin, kidneys and intestines.

It is well for us to keep before us as we study disease and methods of relief, this process of fragmentation and selective passage through different membranes which is essential to the proper main-

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tenance of the cells composing our tissues and organs. The membrane of certain cells will admit the penetration of certain colloid substances. If these are compatible with the plasma of the cell a certain number will be assimilated without appreciable change in the nutritive equilibrium of the cell. If, however, the substances have some incompatibility the equilibrium is changed and at once a physico-chemical reaction takes place both in the invaded cell and in the invading particle, and we have a unit of disturbance which when extended to a large mass of units constitutes a disease which we recognize through resultant clinical symptoms. This disturbance in equilibrium is what determines the formation and expulsion beyond the protecting membrane of antibodies, the presence of antigens in the circulation, the phenomena of anaphylaxis, etc. Investigators like Sherwood-Dunn declare that all forms of chronic diseases and symptomatic manifestations of non-contagious origin appearing in the human subject are the results of a precipitate formed by the combination of an antibody with an antigen; and that the majority of symptoms are explained by the formation of this precipitate which obstructs capillaries, causing in consequence a sudden break in nutritive equilibrium in the cells of various tissues, particularly of the nervous system. Resulting lesions depress organic functioning and are the direct or indirect cause of the symptoms of skin, digestive and joint affections, rheumatism, gout and other diseases. It is certainly logical to stress these bio-chemical considerations when we stop to consider that the very presence of life in the human body is in the final analysis dependent upon chemical processes. Of course vital activities cannot be considered to be governed by the rules of simple chemistry. There exist factors which modify these processes and many of these factors are as yet unknown. It is sufficient under our present knowledge to define life as a succession of chemical reactions occurring in the colloid medium throughout the body.

NERVE ACTIONS

In this process of life the cells of the body which carry on the functions are to a considerable extent controlled and regulated by impulses generated by cells in organs, near or distant, which are conducted by specially evolved structures. These are the nerve actions, conscious or unconscious, cerebral or vegetative, and their importance must not be lost sight of when giving consideration to vital phenomena whether normal or abnormal. We must keep in mind not only that the involuntary nervous system controls the heart, stomach, intestines, kidneys and all the varied processes of our unconscious life; but we must remember that this involuntary nerve system is again divided into two opposed but balanced parts, the sympathetic and the vagus. In the control of the non-striated, involuntary muscle the vagus division inhibits and the sympathetic accelerates heart action; the vagus division contracts the stomach and intestines; the sympathetic aids in their dilation. It is perhaps difficult to regard sensation, intelligence, reflexes originating in memory or instinct, and like nerve phenomena as having a definite influence on the physico-chemical equilibrium of the individual cells of our bodies; but nevertheless it is the nervous system which as the last resort has most to do with the establishment of normal nutritive stability of the cell units. The single familiar example of the sight of food or savory odors causing the sensation of appetite and the secretion of gastric juice, will suffice as an illustration and suggest the train of physiologic experiences that must invariably have its final effect upon the cell.

McDonald calculates that the vegetative or unconscious nervous system which has the double function of stimulation and inhibition applied to smooth muscle and to every organ of the body, expends daily three-fourths of the total human energy expended, and this in processes beyond the control of the will. The regulation of the blood capillaries alone, in a moderate sized man amounts to the control of an area of 120,000 square yards, and this is only one function of the vegetative nervous system. Another function of vast importance to the maintenance of nutritional stability is the influence upon the smooth muscle of the gastro-intestinal tract, where from study by fluoroscope and x-ray plates the actual balance of the action of the two divisions of the vegetative system (the vagus and the sympathetic) can be definitely determined. It has been checked by many hundred x-ray plates to demonstrate the contraction in the gastro-intestinal tract under vagus preponderance and the dilation under sympathetic preponderance. Likewise under vagus preponderance there is a definite increase in hydrogen ion concentration in the blood, while in sympathetic preponderance there is a decrease in the

hydrogen ion concentration. It does not take much argument to reach the conclusion that therefore the acid tendency under the vagus and the alkaline tendency under the sympathetic might become a very potent influence in maintaining or disturbing the equilibrium of cell normality. Furthermore it is found that certain elements, notably Na and K, increase the sympathetic action, and also increase permeability of membranes, conductivity and dispersion of colloid; while other elements, notably Ca and Mg, increase vagus action, decrease permeability and conductivity, and favor coalescence of colloid.

On these grounds a division of disease has been made into two classes: (1) vagus preponderance, and (2) sympathetic preponderance, and as an example of the definiteness of this division the condition of blood pressure may be cited. Substances which decrease blood pressure, like Ca and Mg, are vagus stimulants. They make urine acid and make blood plasma less alkaline. Substances which increase blood pressure, like Na and K, are sympathetic stimulants. They make urine alkaline and make the blood plasma more alkaline.

ACIDITY AND ALKALINITY

It becomes very evident in biologic study along these lines that above all the essential factor in normal maintenance of the cell is the establishment and the continuation of an equilibrium between acidity and alkalinity, and that the loss of this proper balance within the cells means invariably the death of an organism. This fact has led to the theory that the reason for the necessity of maintaining this balance is that electricity through constant chemical action is generated somewhere in the tissues of our bodies and that this electricity is essential to life; and that, although life may be dependent upon a succession of chemical changes in the organism, these chemical changes have to insure certain reactions or decompositions that will develop electricity; and that conditions must permit the storage and conduction of electricity or the organism will not survive. The colloids of the human body are neutral and without potentiality until they are vitalized or given charge by electrolytes, which are compounds that are decomposable by electric currents. It is in supplying these electrolytes that the inorganic salts, although composing only about 2 per cent of the body weight, are of supreme importance for they determine the potentiality. The relatively acid cell with its semi-permeable membrane existing in an alkaline medium is dependent upon these salts for the development of electricity and the continued manifestation of life.

Crile, who with his associates has devoted a great deal of study to this subject in the past eighteen years, has recently published his conclusion that all of "the normal and pathological phenomena of man and animals can be interpreted in electrical terms"; that "the human body contains abundantly the constituent elements necessary to produce and store electric energy; and the animal organism as a whole is enmeshed in a network of highly specialized electric conductors—the nervous system." Without going into the details of his fascinating bi-polar theory of life it is enough to summarize his idea that every living cell of the organism has an acid colloid, the nucleus, which is separated by a semi-permeable film or membrane from the alkaline cytoplasm and thus forms "a complete electric cell with an electric potential existing between its positive and negative poles." He believes the potentiality is due to and is maintained by oxidation; and that living cells are adapted to the accumulation of electric charges. Incidentally, with this premise established the gap in evolution between the living and non-living is indeed a narrow one and leaves but little to bridge between the atom and man.

If Crile's theory is correct and each living cell a complete electric unit, figuring the electric capacity represented by the 28 billion cells estimated by Sir Arthur Thompson to compose the average human body, these cells spread out in a single layer would cover nine acres, and the electric capacity of the cells of an average man would be equivalent to that of a Leyden jar 0.3 millimeters in thickness with a surface area equal to an average city block. This gives an idea of the electric energy of which the body is capable and as that energy is dependent upon a nice balance between acid and alkali it suggests the importance of food intake, digestive functioning, metabolism, oxidation, waste disposal, and all the other factors involved in maintaining normal nutrition. It suggests how potential energy may become kinetic and develop remarkable manifestations of activity, muscular, nervous or mental; of fever; or, on the other hand, under different conditions of how fatigue and exhaustion may follow the disturbed balance. The power of the cell to accumulate and

store up electricity makes us think of the possibility of storing energy in a potential state which may later become kinetic from radium, from the rays of the sun, or the fabricated rays from the quartz lamp. It is compatible with the experiments of ray activation of foods in the nutrition of animals, which we have heard reported from the State University of Wisconsin.

Whether we reject or accept the different theories and hypotheses that come to us from the laboratories, no thoughtful clinician can study his diagnosis or apply his surgical or medical therapeutics to a given case, without keeping in the background of his reasoning the thought of the ultimate cell, the importance of its balanced integrity and the factors in the case that influence that balance.

IMPORTANCE OF BIOLOGIC ASPECTS

The consideration of the therapeutic history of a single affection, like arthritis, may illustrate the importance of stressing biologic aspects. Let us go back a comparatively few years and recall the enthusiasm with which we received the demonstration of focal infection as an etiologic factor in arthritis. The soundness of the theory, the corroboration of clinical evidence, the reports of brilliant successes in applying the theory therapeutically started a wave which effectually swept the profession off its feet and left but few standing on solid ground. The bacteriologist, the roentgenologist, the exodontist, and the tonsillectomist were the four horsemen of this drama. The profession heaved a sigh of relief and the wheel-chair manufacturers looked forward to a dull season, while the newspaper doctor oiled his typewriter and under his caption of "Health Hints," or "This Body of Ours" advised all rheumatic sufferers to disregard any diet regulations, wear BVD's and lisle sox the year around, live in any climate, sleep out in the rain, throw physic to the dogs, but for heaven's sake get rid of teeth and tonsils. The spotlight was shining in an important place, there is no question about that. No clinician could be so dull as not to appreciate that something valuable had been uncovered, something that was going to stay. But it was not a very long time before it became evident that the eradication of a definite focus or two very rarely cured the arthritic. It was plain that where one organ or set of organs had been invaded, various organs or various tissues throughout the body were very liable to be infected by the same strain of bacteria; and it became no infrequent experience for patients to be deprived not only of teeth and tonsils, but the gall-bladder, appendix, prostate, any possible locus for germ lodgment, and often simply on suspicion. This procedure also to my mind needs little argument to justify its propriety. Perhaps the pendulum swung too far, but it was going in the right direction.

But when the clinician finally had delivered back to him by the throat man, the dentist, the G-U man, the gynecologist and the general surgeon, what was left of his patient; and he watched for months and years as that sufferer continued his old disheartening, limited life in the bed or wheel-chair, the consciousness gradually stole over him that perhaps the spotlight should have been spread about a bit, that it should have included some biologists, physiologists and chemists. What was it in the toxemia from the infected foci that caused the knee to swell and the shoulder and wrist to make him writhe with pain? It was a physico-chemical process. It was a disturbance in the cells of the affected tissue that caused a break in acid-alkali equilibrium, a profound nutritional unbalance, an invasion of the cytoplasm by some incompatible albuminoid particle, the development of an antibody, a precipitation by the combination outside of the cell of this antibody and an antigen, a consequent obstruction of capillaries with a vicious cycle of further nutritional embarrassment, a disturbance possibly in the electric potential of the cell, the sudden change of energy to a kinetic state. It is not difficult to conceive of any one, or of a combination of two or more of these phenomena occurring in the cells of the affected tissue.

But why should this action of toxins carried by the circulation to every portion of the body, have a selective action for the cells of articular or periarticular structures; why should others select the lining of bursae? This is evidently a problem for the solution of the biologist and the chemist. Whether it be in the permeability of the walls of the affected cells; the conditions of circulation in the tissue; the readiness with which the local capillaries are occluded; the colloid plasma in which these cells are bathed, there is some idiosyncrasy in these cells or their environment or in the combination, which leads to susceptibility to a physico-chemical unbalance in the presence of certain toxins. And to my mind in this very postulate

comes the biologic reason for much of the failure and disappointment in the clinical care of arthritics.

It does not seem reasonable that the chemical composition of the toxins elaborated by bacteria should be the only formulae capable of causing physico-chemical disturbance in cells as susceptible as are those in and about the joints of arthritics. It is far more probable that sources other than bacterial exist and are active in the supplying of chemical substances to the circulation that will act almost identically with bacterial toxins in affecting the susceptible cells in question.

FOOD SELECTION

This brings up directly the consideration, taken up earlier in this discussion, of the selection of food and drink and its passage through the membrane of the digestive tract and probably even more importantly through the cell membrane. It calls to mind the importance of the selection of the inorganic salt intake and of food substances that will not break up into toxic compounds; the necessity of the proper supply of gastric juice for the preparation of these substances for passage through the gastro-intestinal mucous membrane into the circulation; the proper condition of this mucous membrane which might readily be in a congested or other abnormal state and cause the passage into the blood of incompletely digested albumins (bacterial or alimentary) which might act as antigens, or might prevent the normal passage of desirable, nutritive substances. All of these factors and others that could readily be listed suggest that when the foci of infection have been removed in an arthritic but one of many therapeutic demands has been served. It is no unusual thing for the clinician to find his patient with arthritis suffering frequent acute exacerbations even after a most exacting diagnosis of all phases of the condition and after following faithfully a well-ordered course of treatment. Foci have been scrupulously removed, the diet has been selected after an elaborate blood chemistry has been done; excretion and elimination have been regulated; local treatments with diathermy or quartz lamps. or other devices have been instituted; nothing apparently has been neglected, and yet the patient suffers relapse after relapse. No doubt many of these cases are absolutely beyond our control, but equally without doubt there are some phases of our investigation and management of the case that could be improved if we would keep as a constant background the biologic conditions. As an example consider particularly the matter of blood chemistry and diet.

Probably there is no more frequent abnormal chemical finding in the blood of arthritics than that arch-enemy of joints, uric acid excess. It is also true that a carefully regulated diet, with a faithfully observed regimen of bathing, exercise and hygiene, a satisfactory elimination and other symptomatic treatment will control to a fairly satisfactory degree the distressing manifestations of this toxemia. Therefore the arthritic patient is subjected to a search for an excess of uric acid in the blood and when it is not found he is permitted great freedom in his diet; and yet I have the records of patients whose blood showed no uric acid excess and yet who invariably suffered attacks after a meal rich in purins and other uric acid forming elements in food and drink.

Furthermore, in carefully studying some of these patients I subjected their blood to chemical analysis during the height of an attack and have found at that time an excess of uric acid; and have had the satisfaction of finding the frequency and virulence of their attacks greatly diminished by appropriate treatment. It is an important point to remember that the changes in the chemistry of the blood are so rapidly accomplished that a single blood chemistry done during a period of remission and health is not only of small value but may be mischievously misleading and permit a patient to continue in a state of invalidism that might have been largely avoided.

Another and very important aspect is illustrated by the arthritic patient who follows as faithfully as could be expected the regulations laid down for him; but who, despite all care even with blood studies during the disease, occasionally suffers a very marked attack. We are at a loss to account for his downfall until the womanly instinct of his wife leads her to tell us out in the hall that she knows what is the matter—"He has worried himself into the attack"—and he has. All she knows is that his breath is bad and he sleeps poorly; and she says he is bilious and has nervous headaches. She does not know that the loss of his position in the office; or the two hundred shares of Aero-Express stock he is carrying; or the lawsuit over some automobile accident has affected the nerve control of his gastric secretions and developed irritation of

his gastro-intestinal mucosa, caused the absorption of substances that are toxic and which, passing into the circulation, eventually disturbed the acid-alkali balance of the susceptible cells in his left knee and right ankle. But just that sort of thing does happen, not only in the gastro-intestinal organs but in other organs of the body, and he would indeed be an inexperienced observer who could not furnish trite examples.

The applications of the biologic considerations of disease are seemingly boundless. In the general, symptomatic care of patients with ordinary ailments, possibly one is excused for not keeping in mind what is going on in the cells of the body; but in the problem conditions that challenge the best we have in us for a solution, we are hopelessly lost unless we recognize what Huxley called the "intimacy of connection between medical and biological sciences."

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Fractures*

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Constituted human authority has decreed with superhuman finality that such reapposition of fragments as will restore normal anatomic alignment, the fixation of fragments so realigned and the continuation of fixation with immobilization until firm bony union permits of reactivation shall be fundamental in fracture therapy.

These are the dogmas upon which are based the orthodox treatises upon fractures that have dominated and still dominate teaching and practice and that have, dogma-like, obstructed progress. This influence is remarkable because the dogmas were promulgated before the existence of cells was suspected, when concepts of reparative processes were necessarily fantastic. Moreover, the infallibility of doctrines builded upon dogmas is attested, paradoxically, by the one source of knowledge that is of certainty fallacious, namely, statistics.

The very statistics cited to prove that sundry bones require definite periods for repair after fracture and that the rates of repair are minimal when orthodox requirements are met can be otherwise interpreted in the light of facts established by Nature and by experience. First, the rate of repair is retarded by avoidable immobilization; second, the duration and degree of disability are exaggerated in patients so treated; third, the proportion of patients who achieve unsatisfactory recoveries is higher than their injuries warrant; fourth, the number of deaths resulting from inactivation inevitable with orthodox methods is unnecessarily large.

Treatment of fractures, just as the term indicates, is automatically reduced to a routine. A diagnosis of the nature of a fracture and of the bone affected is referred to statistical tables and the necessary mechanical methods are automatically established. Attention is focused upon the broken bones. Patients receive scant consideration, lose individuality and are regarded and recorded as cases, appropriately enumerated for use in future statistics. In consequence, a considerable number of practitioners refuse to be harassed by the tedium of such methods and to bear the responsibilities for the frequency of failures.

The frequency of failure to promote prompt recovery of function is attested by the growing resentment of industry to economic losses resulting from disabilities consequent upon fractures which are disproportionate to the severity of injuries, by the findings of industrial commissions and by the creation of fracture boards by surgical organizations to discover more effective measures.

Happily, there is another and more inspiring viewpoint. The desirable achievements of treating patients suffering from broken bones differ not at all from those of other ailments. They are to provide full opportunities for the recovery of function with the least danger and distress and without avoidable delay. Such objectives can be attained only by adapting methods to cooperate with

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Nature's processes which provide resistance, defense and repair, the attributes that have made evolution of higher organisms possible and that determine the longevity and potentiality of each individual.

The algebraic sum of the actions of irritants and of the local and systemic reactions to their irritations constitutes the offense-defense ratio which determines the characteristics of a disease, whether acute or chronic, recoverable or irrecoverable spontaneously. Interpretation of the ratio simultaneously establishes therapy. Local lesions, produced by direct action of a pathogenic irritant upon peripheral foci, are controlled chiefly by the quality and quantity of blood delivered to them. They are morphologic indices of existing offense-defense ratios and are mainly responsible for the physical evidence, the signs of disease. Central lesions are provoked by indirect action of the irritant and by the consequences of the local lesions. They provide the functional evidence of the existing offense-defense ratio, the symptoms of disease. They are particularly significant in the circulatory apparatus, the central nervous system, the liver, gastro-intestinal organs and kidneys because these structures provide, control and safeguard the processes that produce the resistance, defense and repair essential to continued existence.

Manifestly, the chief therapeutic obligation is to assist each individual to maintain an equable circulation of good blood effected so economically that expenditure of energy shall not exceed replacement of energy because life continues as long as these conditions obtain. Minor obligations are to reduce the intensity and the duration of action of irritants and to improve the quality and to increase the quantity of blood supplied to local lesions.

Guidance to a selection of suitable methods is provided in a few biologic aphorisms. The sources of energy are ingesta and sunshine. Energy is expended in responses to the stimuli of health or the irritations of disease. As long as the blood-forming and cardiovascular structures are competent and under vasomotor control, the amount of blood delivered to any structure is apportioned to support the activities of its constituent cells, whether their metabolic rates be increased by exercise or disease or reduced by non-use, fatigue or exhaustion. Subnormal degrees of activity are accompanied by equivalent grades of hypoemia and of atrophy of the cells involved. Atrophy is greatest when non-use is enforced and proceeds through various grades of decreasing recoverability of structure and function to necrosis. Recovery of function, reduced by injury or other pathogenic agencies or through non-use enforced by treatment, is certain to be more complete if the inactivation is limited and less prolonged.

PRIMARY AND SECONDARY REQUISITES

Application of therapeutic principles to conform with Nature's processes in treating patients suffering from fractures is as simple as the indications are positive[1]. The primary requisite is attention to hygiene, proper nutrition, direct exposure to sunshine together with the least interference with systemic and local activities. The secondary requirements are to secure or promote such reapposition of fragments as will assure recovery of function, which is unrestricted active motion, to maintain the reapposition so as to interfere the least with local and systemic activities and to encourage reactivation as promptly as may be without impairing the ultimate recovery.

The near-modernists, who are dissatisfied with orthodox therapy and are seeking better methods but methods based upon less heretical fallacies than biology, need not despair. Lucas-Championniere[2] can be accepted as human authority for similar procedures, an authority untainted with the degrading sciences developed since his death.

The accomplishments of treatment of patients suffering from fractures conducted in accordance with Nature's demands have established their superiority to those conforming with empiricism. Examples will be cited as evidence of the advances already made and as indices of future achievements.

Simple fractures of the skull are of themselves no longer cause for concern. Attention is directed to the prevention of subsequent intracranial hypertension and to its correction by suitable modification of the cerebrospinal fluid. Craniotomy is reserved for the checking of hemorrhage and removal of clots, decompression for the release of tension otherwise uncontrollable. Compound fractures are treated so as to reduce the likelihood of meningitis and fungus cerebri.

Fractures of vertebrae, uncomplicated with injuries to the cord and not liable to dislocation,

usually escape detection and do no harm. Those recognized skiagraphically are known to require little, if any, inactivation. Patients suffering from such fractures are commonly better served if uninformed of the exact diagnosis. Broken backs are of such ill-repute that many patients may not recover if they know the reason for their minor discomforts.

Similarly, those individuals with uncomplicated fractures of the pelvis are more apt to continue to be active if provided with a swathe to limit distress and if told their disability will be dispelled by walking as usual. Their recoveries are excellent and surprisingly rapid, particularly if the exact diagnosis is confided only to a responsible friend or relative.

Simple fractures of ribs and sternum are so distressing that over-activity is automatically inhibited. Swathes affixed about the entire chest are helpful temporarily. Recoveries are the more complete if patients will accept the discomforts of getting about soon after injury. Treatment of compound fractures is designed to obviate suppurative pleuritis.

Impacted fractures of the neck of the humerus require only persistent active motion, increasing in range and in power. Carrying of heavy weights is contraindicated until stiffness and pain subside.

Complete fractures of the shafts of humerus, radius and ulna are quite certain to require external fixation after reduction; rarely internal fixation is necessary. Splints are preferable to plaster casts which exclude sunshine. Unabsorbable foreign bodies are undesirable in internal fixation. Frequent change of dressings, passive and early active motion and suitable massage while the dressings are off and the necessary fixation is supplied manually, hasten repair. Fractures near joints, especially Colles' fractures and epiphyseal separations about the elbow, demand longer mechanical protection and greater attention at intervals when dressings are changed to obviate distortion of fragments by muscle pull before they are firmly reunited.

Impacted fractures of the neck of the femur require neither fixation nor immobilization and can be treated solely by active motion. At first weight-bearing is inadvisable, but it can begin within a week restricted to slight pressure while walking with crutches. Weight-bearing should be increased gradually but constantly so that walking with a cane can begin in three weeks provided skiagrams do not show material atrophy and the lines of stress are properly accentuated.

Many unimpacted fractures of the shaft of the femur, even those comminuted and involving the distal portion of the neck, can be held in sufficient approximation by a Thomas splint until repair, hastened by active motion permitted with the splint suspended by ropes and counter-weights to an overhead frame, is well inaugurated. Then a Hodgen splint may be substituted. The patient walks on crutches and increases weight-bearing steadily. Almost complete recovery of function may be achieved by the time a cast would usually be removed. The cruelty and danger of trussing patients in body and thigh casts with legs abducted are virtually always unjustified.

Fractures of the patella can be retained in approximation if the bone is encircled with a band of fascia. Smooth healing is promoted and fixation is strong enough to permit early and gradually increased active motion.

Pott's fractures and those involving the tarsal and metatarsal bones are prone to cause prolonged disabilities, intensified if the extremity is incased in plaster of paris. The remarkable difference in the rapidity and extent of recovery when instead of casts these extremities are supported by adhesive plaster corsets and the patients are encouraged to walk a few steps at a time as naturally as pain permits and with little support indicates the advisability of such heretic tortures.

CONCLUSION

The conclusions to be drawn from the greater efficacy of treatment designed to combine the virtues of artificial and natural methods of treating patients with divers types of fractures are but two: 1. The patients profit by an earlier and more complete recovery of function with less danger to the infirm and with less total distress. 2. Such methods eliminate routine, introduce the essential element of individuality into treatment and convert it from a bore to an engaging effort to minimize disability and economic wastage.

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Backache*

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Backache is a condition of importance to all of us. No matter whether we practice general medicine or one of the specialties, we are called upon by patients to give them relief from pain in the lower back, usually in the lumbar and sacral regions. This pain may be of constant or intermittent duration and may vary from a dull ache to a severe, sharp, knife-like thrust. It may be confined to one location or may radiate up the back or down the thigh and leg to the foot. A sensation of numbness may accompany the pain.

If we are careless or have not the time to pay sufficient heed to the patient's complaint, our results are apt to be poor and the patient becomes a wanderer and feeder of the cults. With a little care and system in our study of cases, the majority of these people are easily relieved and usually by a very simple method of treatment. One of the requisites for treatment is a diagnosis, and like everything else in medicine, a diagnosis calls for a careful history and thorough physical examination.

By a careful history we can frequently eliminate such conditions as gall bladder disease, or gastro-intestinal, renal, syphilitic, or tuberculous lesions that are occasionally the cause of pain in the back. As regards the back itself, the points of interest to be brought out in our history are:

The presence or absence of trauma; location and character of pain; radiation of pain, if any; the motions or position that alleviate or aggravate the pain; occupation of patient, and his characteristic occupational posture.

The physical examination is of equal importance and if one is systematic in his method of examination, a great deal can be learned in the minimum of time.

The patient should, in all possible cases, be stripped. The routine we follow is:

(1) To note the general posture of the patient in the standing and then in the sitting position; increase or loss of normal spinal curves; the presence or absence of list or scoliosis and the presence of muscle spasm.

(2) By palpation the points of tenderness; the presence of muscle spasm and sometimes the presence of a slight spinal deformity that has escaped the eye can be brought out.

(3) Spinal motions: (a) Patient in standing position with feet together and the knees straight. Patient is asked to bend forward, backward and to either side; also to rotate his trunk to either side; any limitation of motion and point of limit should be noted.

(b) The patient in sitting position, the same motions are demanded and the same points are noted as above. This posture eliminates the leverage of the ham strings on the pelvis and is of importance in differential diagnosis.

(4) Hip motions. Each hip is put through its range of motions and these are recorded. Any limitation of motion is of interest as is the presence of pain and the degree of motion that caused the pain.

(5) Measurements. The length of each leg and the circumference of the calves and thighs taken at similar levels should always be noted. A short leg is frequently the cause of strain and a diminution of circumference is often a clue to a neurological or inflammatory joint condition.

(6) Neurological. The various reflexes should always be tested and the sensations should be tested when there is any suspicion of a nerve involvement.

(7) Special tests. These will be taken up in detail under differential diagnosis.

(8) X-ray. Practically all but the most evident back cases should be x-rayed. The general fault in most back cases is not to take x-rays rather than taking them too often. Stereoscopic and lateral views are of much more importance than flat plates.

DIFFERENTIAL DIAGNOSIS

After having all of the data available from our history and examinations we are confronted with the differential diagnosis and the treatment of our patient. "Backache" probably calls to our mind the old terms, lumbago, sciatica, lame back and sacro-iliac trouble, which unfortunately in the past have been but mere labels, indiscriminately applied to any and all types of pain in the back.

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Our present conception of lower back pain is based on the etiological and pathological factors present. Etiologically, we may roughly divide all cases of backache into three large groups:

(1) Those due to static or postural strain;

(2) Those due to trauma;

(3) Inflammation of joints due to infections or trauma.

POSTURAL STRAIN

Probably the largest percentage of cases seen in the average physician's office practice is that due to some type of postural strain. In 1910 Reynolds and Lovett, after careful experimental work, determined the center of gravity in the human body in the upright position and noted the effects on posture and the general bodily musculature in changes from the normal. It was shown that increased work was put on the back muscles when the center of gravity was displaced forward and if this was sufficiently long continued, it produced backache and strain. In good posture the center of gravity falls in a line, running from the tip of the mastoid, through the front of the shoulder, greater trochanter, just behind the patella and about one inch in front of the external malleolus. In this normal position the person bears much of the weight on his bones; very little weight bearing being done by muscles or ligaments. Variations from the normal will naturally throw more work on the latter structures and this eventually leads to fatigue and pain. These posture cases, as a rule, give no history of trauma; they give a history of fatigue that is eventually followed by pain. The fatigue is worse after having been up and about for some time, and is usually relieved by rest. On inspection, a poor or faulty posture is easily discernible. We have three types of habitual, faulty posture:

(1) Poorly nourished young people who stand with round back and shoulders, with perhaps some degree of lateral curvature.

(2) Those who hold their heads and shoulders drooping forward, their abdomen being prominent, with increased lumbar lordosis. This type is usually seen in thin women.

(3) Large, obese individuals who hold their trunk inclined backward in order to maintain their body balance. In most of these cases, as part and parcel of the general poor posture, we find flat, or at least, pronated feet. There is usually but very slight, if any, muscle spasm; there is a tenderness of moderate degree present over the back muscles and over the sacrum; spinal motions, as a rule, are normal and all special tests are negative. In all these cases, but especially in those with some slight lateral deviation, measurement of the legs is important. A short leg may be the entire cause of the pain and when this inequality in length is compensated or by increasing the height of the heel or by a lift in the shoe, the symptoms immediately disappear. It is also wise in these cases to pay attention to the feet. Elevation of the inner side of the heels of from 1/8 to 1/4 of an inch is indicated in pronated feet. In feet with short heel cords (the normal foot should be able to be dorso-flexed ten degrees above right angle) an increase in the height of the heel frequently gives prompt and considerable relief.

For the immediate relief of backache, strapping with adhesive followed by a properly fitted corset and exercises for improving the posture are indicated. In strapping these cases, we have found that a long strip two inches wide to either side of the spine extending from the gluteal fold to the level of the shoulder, with two broad transverse strips across the pelvis, gives most relief. In large, obese individuals the corset or belt helps to give relief by supporting the abdomen, thus taking some of the drag from the back. The best type of corset is one with a straight front, back lace, and that extends from the trochanter to the lower ribs in front and the shoulder blades behind. In these static backaches, the x-rays are negative. Frequently it is found that occupation plays a part in posture, for having to work hours a day in a bent or stooped position is conducive to strain, as is also the poor sitting posture we so often note in drivers of automobiles. Under the heading of "Postural Backache" we may include those cases belonging to gynecological conditions. We do this because so many of these patients have associated postural defects. There is no question but that displacement of the pelvic organs is a frequent source of backache in women, although this source is more apt to be over-rated than under-rated. Graves has shown that a large proportion of cases with retroverted uterus have backaches and that this backache is usually relieved by operative correction. This type of backache is invariably confined to the sacral and lower lumbar regions. MacFarlane, Hutchins and others have shown that lacerations, prolapses, inflammatory conditions, anteposition of

uterus, etc., have also been the cause; at least, when these cases have been corrected many of the cases of backache have disappeared. On the other hand, numerous similar cases with definite orthopedic conditions, such as faulty posture, have not recovered following their gynecological operations but have cleared up with supports and exercises. Because of this fact, it would be wise before operating for the relief of backache to try the more simple means of support. As so many cases of sacro-iliac and lumbo-sacral type develop following pregnancy, it would be a wise precaution if all mothers, at least during the nursing period, were given some form of adequate pelvic support, such as a well fitting corset.

TRAUMATIC ORIGIN

In industrial practices and in hospitals the large proportion of our backaches are of traumatic origin, or at least a history of trauma of varying degrees, is obtainable; the question that confronts us is as to the degree of injury and its location. As the result of moderately severe trauma, we may have a compression fracture of one or more vertebrae or a compression of the inter-vertebral disc without any apparent serious disability being noted at the time. The patient may be able to get around without any great difficulty, although he will have a certain degree of pain in the back. On examination, we note that the patient handles himself guardedly. We may or may not be able to discern a slight increased kyphosis. This is apt to be more evident on palpation than on inspection. There is usually a marked tenderness over this region. All spinal motions are markedly limited in the region of the injury. X-rays are of great importance in these cases, especially a lateral view. Treatment is preferably to put patient to bed on a hard mattress, with extension on legs, keeping the patient in bed until the acute tenderness has disappeared, then apply back supports, either a plaster cast or a back brace, preferably the latter, supplemented with hot compresses and massage or diathermy. As a result of direct or indirect violence, fractures of the transverse process of the vertebrae may occur. These cases are characterized by marked pain and localized tenderness of the fractured process, with restriction of motion that causes the tenderness on the affected part. An antero-posterior view of the spine will confirm diagnosis. A longitudinal strapping of the back, as done for static backache, gives considerable relief. This should be followed by baking or massage or diathermy.

Probably the largest number of back cases that we see are those the result of mild or moderate trauma, causing a tear of muscle fibers or ligaments about the lumbo-sacral and sacro-iliac joints and in the more severe type, strain or sub-luxation of the joints themselves.

Bones, muscles and ligaments all have their definite place in the proper functioning of the back. When circumstances, such as muscle fatigue, sudden stress, over-loading, unusual posture, etc., occur, one or more of the above elements are at a disadvantage and tears of the muscles and ligaments or subluxation of the joints result. Tears of muscle fibers heal more quickly than tears of the ligamental structures, and in the presence of toxic or infectious foci, the period of repair is apt to be longer than usual. Lumbo-sacral and sacro-iliac strains are both characterized by pain in the lower back. In both, pain may be referred down the leg. This referred pain may be due to actual pressure on nerve trunks or, according to Smith-Peterson, it may be due to a reflex innervation similar to the referred pain in the knee in case of tuberculosis of the hip. In lumbo-sacral strains, the nerve trunks of the fifth lumbar and the first sacral segment are usually affected and here the pain is distributed over the front of the thigh and dorsum of the foot. In sacro-iliac joint conditions the second sacral segment is usually involved and its pain referred to the posterior aspect of the thigh. In both lumbo-sacral and sacro-iliac lesions there is more or less lumbar muscle spasm. In the former tenderness is most marked over the lumbo-sacral and lumbo-iliac ligaments; in the latter we find most tenderness over the lower half of the sacro-iliac joint and the upper portion of the sacro-sciatic notch. In both conditions there may be a list to one side or the other. The spinal motions, when standing, especially forward bending, are limited in both conditions. When sitting the ham string leverage being removed, forward bending is much less limited in sacro-iliac than in lumbo-sacral strains. Special tests are of importance in differentiating these two conditions. The important special tests are:

(1) Straight leg raising. When straight leg raising causes a referred pain to the back before leg has been raised more than forty-five degrees, it is significant of a sacro-iliac strain; when raised

more than forty-five degrees, it may be either sacro-iliac or lumbo-sacral.

(2) Compression of iliac crest. If compression of the iliac crest causes pain, it is indicative of sacro-iliac lesions. The absence of pain, however, is of no significance. This test is best carried out by having patient lie on his side and then we throw most of our weight on the opposite side of the pelvis.

(3) One of the simplest and best tests is the one devised by Gaenslen, namely, with patient lying on back near edge of table flex one thigh acutely on the abdomen to fix the pelvis and then hyper-extend the other over the edge of the table; this throws a strain on the sacro-iliac joint and not on the lumbo-sacral. Nerve reflexes are usually normal in both conditions. Changes in reflex and atrophy of muscles are rare. When present, it indicates a true neuritis or sciatica. Rectal examinations are rarely done, as they are usually annoying to the patient and of very little value to the physician. X-ray in these cases of strain are usually negative. We may find various anatomical abnormalities; these, when present, are suggestive of a potentially weak back. Treatment in the mild cases, consists of strapping, followed when necessary, by a canvas belt, back exercises, baking, massage or diathermy. In sacro-iliac conditions we start the strapping in front of one anterior superior spine and carry around the back as tightly as possible to a point in front of the anterior superior spine. The back should be plastered from the level of the trochanter to the crest of the iliac. The plaster is applied in overlapping strips, 2 to 4 inches wide. In lumbar-sacral lesions, in addition to the above strapping, two parallel, longitudinal strips, from the gluteal fold to the top of the shoulder are applied. The belt we prefer in these cases is made of canvas with interlacing strips that tighten the belt in the back. In lumbo-sacral cases, we have two steel uprights attached to the belt with shoulder strips coming off from the top of the uprights. In the more severe, acute cases, the patient should be put to bed with traction applied to leg with the knees kept slightly flexed. When the acute symptoms have subsided, patients are treated as described above for the milder cases. In the more chronic cases, manipulation of the spine under anesthesia is often necessary before relief can be obtained. Sacro-iliac slipping or relaxation does occur although demonstrable slipping of the joint is rare. We have seen cases the result of severe trauma, such as being rolled under a car or being pinned under a falling tree, in which there was no question but that there was actual displacement of the sacro-iliac joint. Sever reports two cases in fat women who, as a result of long duration of poor posture, developed greatly relaxed sacro-iliac ligaments. This same degree of relaxation may also occur after pregnancy. Milder types, which cannot be readily demonstrated, are more frequent. As a rule, they are caused by a twisting strain. The usual history is that while bending over lifting something they felt something give in the back or they may feel as though they were breaking in two. The pain is very severe; they are most comfortable when sitting on the opposite buttock; lying may increase the discomfort; all spinal and hip motions are greatly limited and exceedingly painful. X-rays, except in the marked cases, are negative. According to Wentworth, in these cases, there is either a very slight forward or backward tilting of the base of the sacrum and small irregularities on the surface of the sacro-iliac joints are changed enough to disturb their normal relationship with corresponding disturbance in sensation and function. Manipulation, according to the method of Cochrane, that is, by reflexing the thigh to a right angle and pressing downward followed by hyperextension of the hip, usually gives prompt relief to these unfortunates. Cases of recurrent subluxation, if severe, should be treated by an arthrodesis of the affected part.

ARTHRITIS

The last important large class of patients who suffer from backache is in those who have changes in one or more of the joints of the back. These cases of arthritis may result from toxic or infectious foci and from repeated mild trauma. This type of arthritis is most common in middle-aged people, especially those who have been exposed to postural strain and to the elements. Usually the pain is not severe; there are periods of remission and exacerbation and other evidences of arthritis may be present. Frequently the condition may be present without symptoms and is only recognized after some trauma has lighted up the process, thus calling attention to the back. These people usually present a stiff back, all motions being much limited. In localized arthritis the location as to whether it is in the sacro-iliac or lumbo-sacral or

inter-lumbar joints may be determined according to the methods we use in determining strains. Practically all of these cases present some definite foci of infection, such as teeth, tonsils, sinus and frequently the colon. Conclusive evidence is the x-ray. In our x-ray examinations, the points to be looked for are:

(1) Increased densities along the margin of the joint;

(2) Proliferation or destructive changes in the joint;

(3) Irregularities of the joint outline.

The treatment of these arthritics consists of:

(1) The removing of the foci of infection;

(2) By giving support to the back.

In cases where the condition is confined to the sacro-iliac joint and which are not relieved by suitable support, an arthrodesis of the involved joint is indicated. Lesions affecting the lumbar spine are best treated by a traction in bed until the pain and tenderness has subsided and then support the back either by a plaster jacket or spine brace. Local heat or diathermy may aid in giving relief from pain.

CONCLUSION

Summing up, I would state that backache is an exceedingly common condition, that each case requires a thorough study; nothing can be taken for granted and that most cases can be relieved by adequate treatment, this treatment usually being a very simple measure. I feel that many of the cases we see tend to exaggerate their symptoms and I feel that there are very few, if any, real malingers.

For discussions see page 144.

The X-Ray in Diseases and Injuries of the Skeleton*

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One man out of thousands giving years of undivided devotion to his single, great purpose, rises from cabin boy to captain in command of a great ship. All the executive work, the duties and hazards, all the responsibility for lives, property and dividends, depend on the captain's matured judgment. All the work, thought, worry, sweat have built the fine character of this man. Front, assurance, elaborate laboratory equipment, without years of study, thought and a broad foundation of general premedical science, mean lost opportunity to help, betrayal of confidence and deserved defeat for the radiologist. The medical profession has had to make a place during the last 20 years, for this new agent, the x-ray, and it has been like trying to find a place in a crowded room for a large, new piece of furniture. By frequent rearrangement this problem has reached the stage where the x-ray has been accepted as a useful part of our professional equipment, but because this art is so young, many of the men who are specializing in it, were prepared for general practice only. Today there are young men preparing themselves especially for this kind of laboratory work. This preparation consists of study of chemistry, physics, photography, histology, comparative anatomy, pathology, physiology and therapy, with a broad general knowledge of all branches of medicine and the cultivated gift of all modern languages. Give them also, please, a private income from another source so that they may spend their preparatory years in seeing and studying the work of the best investigators and instructors.

In radiology the honest worker will soon decide that he cannot master and remain master of all branches of this science. Let him decide and when he finds one greatest interest and then one field for his usefulness, he will then become trustworthy, a source of help to the profession, respected and happy. From him who adopts ostiological radiology as his field, we ask that he know the life history of every part of the skeleton from the embryo to the adult, in health, disease and injury, and understand the underlying reasons for its structures and all the influence that has gradually, through the centuries, modified the skeleton, to meet the present day demands on it. It is unnecessary in this paper, to give the explanations covering the form and substance of the skeleton. They can be read in any textbook on anatomy, but suffice it to say that a familiarity with paleontology and also ontogeny, the absorbing physical history of the world creatures, are prerequisite to an understanding of our family skeleton. Variations in form, variations in number, are only understood and properly estimated through such

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study. One or more cervical vertebrae, more or less than 12 dorsal, more or less than 5 lumbar vertebrae, are atavistic visitations on the individual. The notochord in the urodeles shows in three stage development connection of vertebrae by intervertebral expansion, connection by intervertebral cartilege and articular connection. The *evolution* of every concavity and convexity, every process and articulation must be studied to account for a man's skeleton. On top of this must be known the occupation and stress of life for which the skeleton is developed. Our natural-history museums show us in striking exhibits the skeletons fitted for draught and race horse, elephant, antelope and monkey. The development of bone foramen to meet the requirements of an artery, shows size, in proportion to size of artery and this in turn is in proportion to the activity of the bone and depends on it through its use. Tuberosities, spines and other processes vary in shape, size and strength directly with muscle and ligamentous pull, weight-bearing and extension. The artery develops the size of the bone foramen and groove through pressure. The tongue molds the jaws through pressure. Pressure and extension stimulate the growth of bone and shape it to meet demands. A study of the development of the cranial and facial bones through the various kingdoms of life, is alone an absorbing story, revealing the only known reason for man's kind of a skeleton. One cannot understand the jaw symphyses unless the precursors of the facial bones are studied. We know the vertebrate skull is not a separate structure, sui generis, but has been metamorphosed from the most anterior skeleton of the body.

To continue would take days, but enough has been said to show that this subject is vast and full of marrow and my point is that unless these matters are understood by the radiologist he will be at a loss to understand the variations daily seen in the skeleton and unable to properly discount them.

The chemistry of bone in health and disease is as important. All these studies have been confirmed and supplemented by use of the x-ray. The study of the *living* skeleton under the x-ray is now possible and we are vastly helped in our understanding of its functions and health. On screen and film, we now record the variations of motion, alignment, symmetry, normal, disease and injury. To see post-mortem that an intervertebral ligament is broken avails us little. To see in life an intervertebral joint, knee joint, or an intercostal space narrowed on one side and widened on the other, frequently means help for a living man. Live bone detail tells us almost as much under the x-ray as under the microscope. Many diseases have characteristic bone changes that are now on record. The location of disease, in shaft, epiphysis, joint, periosteum, cranial vault, spine, ribs or long bones, all mean help in determining etiology and the treatment demanded, because systemic and local diseases favor certain parts of the skeleton and are often found before other symptoms arise. That is one good reason for a *complete* x-ray examination. Under otherwise exactly similar symptoms, one discovers the time is exactly right for operation for mastoiditis, or that it is safely passed and that convalescence can be expected without surgical interference. Now we know when surgery should step in to limit useless and crippling destruction of bone, when and where a focus of infection in the bone can be obliterated and when an early malignant bone growth has started. Spinal kinks and curvatures may have developed so slowly through past injury or disease as to permit perfectly symmetrical growth of the thoracic cage and often cannot be seen unless x-rayed, standing and weight-bearing. A defective knee showing bowing, swelling, pain, may mean Pagets, injured ligaments or one of several other conditions. Flat-foot, sacro-iliac defects and spondylolisthesis are not confused under the x-ray. The periosteal tent of syphilis, the elevation of hematoma and the appearance of periosteal sarcoma can be differentiated by their characteristic markings.

NO PERFECT SYMMETRY

We are told there is no such thing as a perfectly straight line. We can add there is no such thing as perfect symmetry of the skeleton. The right handed man develops a larger, stronger, right skeleton. Spinous processes, tuberosities, foramina, articulating surfaces, develop in size and shape according to the demand on them. Right and left meningeal grooves vary in size and shape according to demand and accommodation. Constant gentle pressure or pull causes a giving way and finally a fortifying of bone structures.

There is more accurate information to be had of the bones in radiology than in any other department of this science. Bactjer and Water's book on

Injury and Disease of Bone is a well known classic and the best work on differential diagnosis of this kind that has been published.

Frederick Law's work on the Sinuses is unique, original and most helpful, but the ear, nose and throat men do not seem, in my experience, to make the most of the x-ray's help. There remains a vast ocean of information to be charted in spine, base of skull and pelvis. Dwight's book on Variations of the Bones of Hand and Foot is the last work on this subject.

In these days of automobile accident all our fracture experience has been revised. In medical legal work skull and spine injuries have proven a busy field for lawyers. Careful study of the dried and fresh skulls, especially under transillumination and x-ray reveals the presence of many forgotten differences in density and fissures. Beware of involuntary perjury, committed because of lack of study of your case. And in that no-man's-land, the skull base, remember that a man with a fracture of the base, big enough to be seen in the x-ray film, rarely if ever lives long enough to get to an x-ray laboratory.

Curiously the profession remains obstinate and will not set fractures under the x-ray screen. A few do, but most do not. This procedure was my original idea and I have therefore continued to advocate it and watch its adoption. It is the only accurate way of setting and aligning a fracture except by open operation, but I find that many men do not know of it. It certainly cuts down the length of the healing period, amount of pain and deformity and most important, tells you at once if the fragments remain in contact. The manufacturers should supply us with an adequate fracture table. The reduction of dislocation ought always to be done under the x-ray screen. Bones and joints are not made of iron. It is astonishing how easily a fresh bone may be broken. Many a dislocation has been followed by fracture in the hands of a husky surgeon who was using brawn instead of brain. That is gross mal-practice. Divided carpals and other variations of the bones of the hands and feet, especially if there has been a history of accident, offer a trap for the unwary radiologist. Most important is the ability to estimate the *age* of the condition and differentiate disease from trauma. This often means thousands of dollars in a medical-legal case. What may mean the normal amount of bone hypertrophy for a man of 50 means some systemic infection at age 20.

Only a person in constant study of these factors can correctly say normal, abnormal, anomaly, or variation, but in common justice we must give the radiologist at least the same percentage of failures in border-line cases, that we secretly allow ourselves in private practice. Remember that this is a new science and progressing very rapidly, as there are thousands of earnest, busy, laboratory men endeavoring to add to the sum of our knowledge, and that today we have learned what yesterday was undiscovered. The information and help that the radiologist could not give you last week, he may have today and one must keep in touch with him to know what he can do. But the help that is in this art, while definite and exact, depends on the patient, the consulting physician and the radiologist, and there are rules of procedure that must not be broken, if the maximum of help is expected from the x-ray.

The consultant must confer with the radiologist as to the information desired and hear what the examination can do. He must then inform the patient as to what is desired and what may be expected from such an examination.

The patient must devote time to any needed preparation and must be willing to submit to and pay for as complete an examination as indicated by consultant and radiologist.

The radiologist must be fully prepared by study and experience to understand and do what is required and to interpret for himself what he sees, and to write an opinion on the facts ascertained after studying them.

The consultant must ask for all the help the radiologist can give, for too many consultations have been failures because the consulting physician resented information and suggestions which were not asked for. Take all you can get and use only what your judgment needs.

IMPORTANCE OF COMPARISON

Last and most important is comparison. Take both shoulders, knees and hands or other duplicate parts if one is under suspicion. It may cost a few dollars more and it may not, but without comparative analysis a growing normal acromion process has been called syphilitic, traumatic or tuberculous. A ridge or other thickening has been called neoplasm and fissures, grooves and epiphyseal lines, have been called fractures. Many times the

overlying pubic and ischial union has been called over-lapping fracture. Many times under oath, an unqualified physician has testified that a meningeal groove was a skull fracture. Insist on taking both shoulders if one of them is under suspicion. Take them stereoscopically and spend hours instead of seconds studying them. Then be guarded as to what you write and sign. It is neither safe nor productive of business to give verbal opinions. Always write them and the radiologist must keep a copy of his opinion and all films on file.

The radiologist depends on the consulting physician for his living and should honestly prepare to serve him when needed and both must abide by the accepted code of ethics. The consulting physician can rest assured that the radiologist has much help for him and his patient. Treat him honestly and give him your confidence, for he will prove a helpful, loyal friend and will lighten your labors.

DISCUSSION

Dr. F. E. Chandler (Waupaca, Wis.): The hour is getting late, and I will confine the few minutes I have to a demonstration of some of the cases of low back strain which have not yielded to relief or have not been relieved by the different procedures mentioned with the exception of arthrodesis. These cases have had backaches ranging from five to twenty years. They have been treated by plaster casts, by splints, braces, strapping, and every known means, including lying in bed for years. Some of these cases are private cases, some are hospital cases, and I have now the good fortune to show one case which has come under my observation following supervision by Dr. Hibbs of New York.

This is an x-ray of the kind which Dr. Smith so well described and to which more and more attention is being directed as a cause of a good many of these backaches. The large mass to the left of the picture is the sacralized fifth lumbar vertebra which in this case is fairly well fused.

This specimen I found in the anatomical la' tory, dissected the pelvis, disarticulated it, and these black marks show the articular surface of the sacroiliac joints. A large mass can be easily seen to the left. On pressure from a superimposed spine, great leverage to the side can be demonstrated. It was demonstrated before the ligaments and fascial attachments were removed. This kind of spine is a very susceptible spine to strain; it is the vulnerable spot. The individual may go through life without any symptoms. On the other hand, the slightest trauma may create almost incurable conditions. Casts and braces worn over a period of years are probably worse than the disease.

We attack this type of case by the arthrodesis method which Dr. Schumm has mentioned.

This is one of our technicians in the x-ray department. She had complained for years of a weak back. Her back became so susceptible to strain that during activity in the x-ray room this girl had to give up about two o'clock in the afternoon every day.

This shows complete sclerosis along both sacroiliac joints, indicating that besides a lateral leverage we have an irritation of some sort or other in the sacroiliac joint. This case has not come to operation as yet. She is tolerating the condition as it is at present.

This girl has the same sacralized fifth lumbar vertebra on one side. She is at present convalescing from her operative procedure.

On exploration of these backs it has been very instructive to find the great amount of flexibility present at the lumbosacral juncture. It cannot be demonstrated except in a few cases by the x-ray of the spine in the weight-bearing and non-weight-bearing portion. In this particular spine not only was motion discovered to be excessive at the lumbosacral juncture, but motion above, between the two adjacent vertebrae, was found to be excessive.

Stability is not compatible with motion in that region of the body. The two lower vertebrae were fixed by an arthrodesis operation through the sacrum itself.

This man was sent to me by Dr. Ryerson in Chicago, an ex-soldier who while in France was run over by a tank. Subsequent to that he had a painful back. There never was a fracture demonstrated. He was given treatment by casts, rest in bed, strapping, braces, and every known means of artificial external support. This is his post-operative picture. This large shadow in this area is new bone which has been thrown down from adjacent surfaces and is now fused into a large mass, transferring all functions which caused motion at the sacroiliac joint to the next higher level.

This is the case operated on by Dr. Hibbs. This woman had been a very active athletic individual, used to mountain climbing, horseback riding, and so forth. Since early childhood this woman realized she had a weak back. She always found relief sitting on the floor with her knees curled up under her chin. When she had a dinner party she found she was relieved only by sitting with one leg under the other, permitting lordosis to a more complete degree.

This woman last February was fused. I have had the occasion of following her since, and the cure is remarkable. To talk with this individual and see her activity at present as compared with the two preceding years is a revelation. There is no doubt that she better mechanical area in this back.

This is another back, with the exception that instead of the sacralized fifth lumbar vertebra we have spina bifida occulta. This is a pre-operative picture, showing the long gap which the posterior ligaments must take at the lumbosacral juncture. In this individual there was also noted sclerosis of the sacroiliac joints. She had been put in casts, she had been wearing braces. There were two factors which I could not differentiate one from the other, and none of our consultants could. In this individual a spine fusion operation was done between the last lumbar and sacral and an extra articular fusion of both sacroiliac joints, through a method which has not yet been published. The relief has been complete. I believe it is of long enough duration to warrant a definite statement to that effect.

This is another individual of the same type with a sacralized fifth lumbar fusion.

This is a scoliosis producing the same mechanical disability at the lumbosacral juncture. This man had scoliosis for years under treatment of one of our orthopedic men twenty years ago. Three years ago, while playing golf, something gave way in his back which was not relieved by braces or casts. A fusion was done, with resulting relief, merely transferring the function from the lumbosacral joint to the next higher level.

Dr. R. S. Cron (Milwaukee): As far as obstetrical cases are concerned we very frequently see backache during the latter months of pregnancy. That backache is due to the same sort of process where there are large tumors present in the abdomen or where there is a large pendulous abdomen.

The most important thing for the relief of backache in those people is to wear a properly fitting corset, and the corset should be applied while the patient is lying down and the parts lifted up as far as possible, sufficient support being given across the lower abdomen. In practically all cases the backache is immediately relieved.

As far as gynecology is concerned, the gynecological patients having backache, I think the belief that retroversion, retro-displacements of various types, are the cause of backache has been greatly overdone in years gone by. When we study, for instance, virgin women and find that twenty per cent of them have retroversions and it is rare for them to have backache, we can realize that retroversion is not a frequent cause of backache. Forty per cent of all puerperal women have retroversion, and at least half of those have no backache due to the retroversion.

Before one operates for a retrodisplaced uterus, I feel the patient should be given the benefit of re-position of the uterus and the wearing of a properly fitted pessary in order to see whether the backache can be relieved when the uterus is in its normal position.

Complicated retroversion, that is complicated by inflammatory lesions, and backache accompanying such pathology is, of course, another question, and there about eighty per cent of the backaches will be relieved by the proper operation.

There is another very important group of backaches in women due to gynecological conditions, and that is where we have a severe cervicitis or endocervicitis. It is very remarkable how these backaches clear up after the patient has gone through the proper treatment for the relief of the cervicitis or endocervicitis. The treatment which I refer to consists in cauterizing the cervix, in radio cauterizations the procedure being done with a small nasal tip cautery. Almost without exception where this backache is due to the cervicitis or endocervicitis, the backache will be greatly relieved almost immediately after cauterization.

Tumors give backache only when they are large enough to cause pressure, and it is the symptoms that arise from pressure that give the backache. The smaller tumors I am sure very rarely give backache in the gynecological patients.

One of the causes for backache results frequently from the treatment of gynecological conditions. We have seen patients develop backache after being operated. The type of operation is usually some plastic operation where the legs have been suspended on stirrups or there has been no rest for the knees and where the patient's back has been put under a strain. Likewise, frequently you see a nurse grasp an obstetrical patient or a gynecological patient in order to get the Kelly pad away, and pull the legs back over the body and in that way hyperflex the thighs on to the abdomen and put a definite strain on the sacroiliac joint. If care is taken in those types of cases and in the treatment of operative cases or obstetrical cases, backaches like that will be prevented.

Hereditary Factor in Inguinal Hernia

BY JOHN T. MORRISON, B.S., M.S.
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Hernia in the light of recent investigation has become well known among industrial surgeons as a disease with its origin in a congenital abnormality developing over a period of years. These surgeons have shown by anatomical demonstration and physiological experiments that true indirect inguinal hernia is only in the rarest of cases entirely the result of trauma. In almost all cases it appears suddenly and is the result of a gradual distension of a congenitally formed sac by intermittent increase of abdominal pressure over a period of years. Trauma is thus the cause of the discovery of the hernial condition rather than the direct cause of a rupture.

Many reports are given in the literature upholding the congenital nature of the disease, placing the cause on the persistence of the fetal tunica vaginalis in the male and the canal of Nuck in the female. These structures normally atrophy shortly after birth leaving a small canal containing no peritoneal sac. The continuance of the peritoneal out-pouching has been considered a predisposition to hernia.

Championiere gives the results of 14 radical inguinal hernia operations in 10 of which he found evidences of their congenital natures. Andrews makes the statement that there are a large number of herniae occurring in individuals who show other congenital malformations.

In very few instances, however, is there any

mention of an hereditary factor in the defect that results in hernia, and no report of cases has been found. Richter has stated that he has noticed herniae appearing spontaneously without other cause in infants whose fathers have herniae. When the statement is made that herniae are hereditary Lawrence says that the observation must mean that there is a defect in the original formation of the parts predisposing to the complaint and that this defect may descend to the offspring. Moorhead mentions that there is a family history in hernia that is often surprising. It points to some transmitted strain of muscular deficiency as typical as a facial feature or a birth mark.

The case reported below is of singular interest, not because of the occurrence of indirect inguinal hernia in the female but because of the family history pointing toward an hereditary factor that has not received much mention.

CASE REPORT

The patient was a married white American housewife of thirty-eight years of age who entered the hospital on July 29, 1926, complaining of hernia in the inguinal region which she had had for seven years. She had some gastric disturbance which was relieved by pushing a "lump" in her left inguinal region "back in." Since seven years ago the patient had worn a truss which partially relieved her symptoms. The usual physical examination showed chronically infected tonsils, a systolic murmur heard over the apex of the lower precordium and transmitted to the axilla, an upper right rectus scar, and a left indirect inguinal hernia. On the diagnosis of inguinal hernia a herniotomy was done with an uneventful recovery.

The family history showed the following facts. Patient's father had left "groin" hernia, and the father's brother had a "groin" hernia. In a family of eight children five had inguinal herniae. Some of these were present from infancy, and some occurred later. In the patient's immediate family of four, three boys and one girl, there were two inguinal herniae. The patient's sister who has an inguinal hernia married a man who also had an inguinal hernia. Of this union a family of four children all showed inguinal herniae. The patient stated that in the family herniae were considered a common ailment. A truss was just as much an article of clothing as a dress or a suit.

The familial condition may be represented graphically. The individuals with herniae are shown by the shaded figures.

A glance at the chart shows that with the patient's family a defect of the father's family was inherited by five of the children. In the patient's family, with the patient having the only hernia of the parents, one-half of the family was herniated. One boy who was not herniated was an infant. In the sister's family with both parents having inguinal herniae all of the children inherited the defect. Another noticeable thing is that as the defect reaches the third generation the age of occurrence becomes younger.

This case is only one instance and proves nothing. It will be interesting in the future to attempt to secure an accurate familial history in cases of inguinal hernia, particularly in women. This case came to Dr. Schmidt's attention in the Wisconsin General Hospital.

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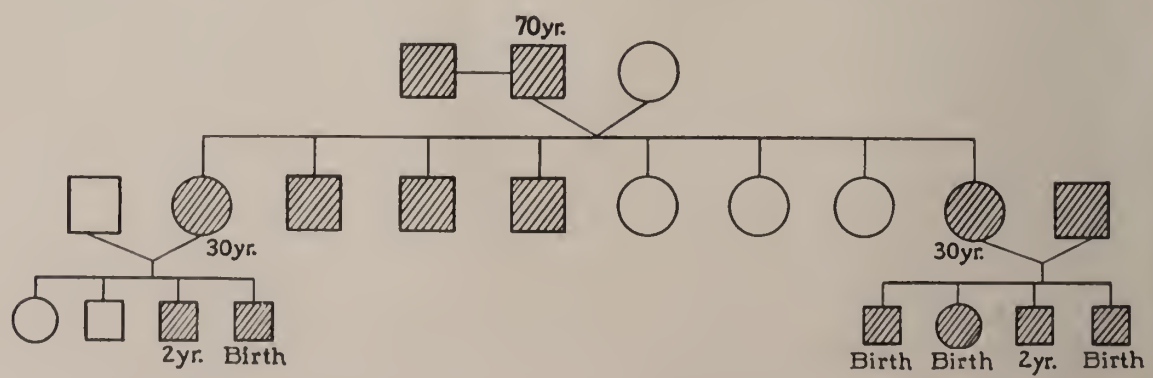

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PREVENTIVE MEDICINE

W. D. STOVALL, M. D., Editor

Periodical Health Examination With Special Reference to the Chest*

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Periodical examinations of apparently healthy persons are not in the first analysis a problem for the specialist. While there seems to be a clear trend toward educating the public to make use of the specially trained and specially equipped physician for special ailments yet the person without any definite complaint or with the mere suspicion of something going wrong belongs to the field of the general and all around physician. In starting a health examination one should not be prejudiced in any regard, even not through a special training, in paying more attention to one organ or system in preference to another. Only in avoiding even the remotest suspicion of biased purposes or of looking for trouble with the intention of finding it, will we be able to popularize regular examinations of not actually suffering individuals.

There is one special field, however, that every physician attempting to establish the state of health of a person, ought to be thoroughly familiar with. No physical examination can be of any value without a more than average knowledge of the clinical anatomy, physiology and pathology of the chest, because the discovery of border line conditions of the chest organs, deciding between absolute health and definite pathology, requires all the skill and experience available. No approximate decision will meet the purpose, as the verdict of normal health being present or absent might carry with it the most far-reaching consequences. *Periodical examinations of presumably healthy persons will not be justifiable unless decisive and dependable, namely, giving to the individual positive information about health or disease, without any evasion.*

It is peculiar that all chronic diseases of the chest organs are in their beginning concealed to a certain extent. With the absence of a typical history and of definite subjective signs one has to depend very often upon the objective findings as revealed by exact methods, notwithstanding the fact that present methods have certain limitations which have to be taken into consideration very carefully. In attempting to establish conditions which are beyond any proof of existence one is apt to discredit the entire proposition.

In taking up the different standard methods of examination that have a bearing on pathological chest conditions the question of differential diagnosis between normalcy and pathology in general and between different chest diseases in particular comes into consideration.

First, we must realize that the physical examination of the chest should be merely a part, although an important one, of the entire investigation. I wonder how many of you are aware of the *incompetency of percussion and auscultation alone* in the diagnosis of a good many borderline cases of chest disease? While we may encounter among the group of seemingly healthy persons some with unmistakable chest findings permitting a definite diagnosis, the majority will not yield more than a scant crop of indistinct signs if any at all. It would show a lack of conscientiousness to draw far-reaching conclusions from faint traces

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of chest pathology, as for instance slight interscapular dullness, areas of harsh or bronchovesicular sounds particularly at the hilum or the right apex, occasional mucous rales in any part of the lungs, slightly increased voice conduction, etc. I do not think it would be wrong in saying that it is not a rare exception that a person is often declared tuberculous on such an unsound basis.

In cases showing the least signs of actual disease it should be our duty to apply every available method of investigation. We are fortunate enough to have at our disposal a choice of laboratory methods, and if used at the proper time and interpreted correctly they prove extremely valuable in avoiding the false diagnoses ofttimes obtained by the use of physical means alone.

CONSTITUTION

There is no need to go into the details of an ordinary routine chest examination. Only a few points might be worth mentioning. Although we commonly try first of all to get a complete history of the patient's past troubles and present complaints, it is recommended that we begin with a thorough *inspection* of the entire personality. We must ascertain the constitutional peculiarities. It makes some difference in the entire procedure whether the individual is of asthenic or pyknic (stout) stature, whether he is blonde with long eyelashes, an African with the well-known predisposition or a well pigmented, well nourished Caucasian, whether he gives the impression of a neurasthenic and hypochondriac or a well poised optimist, or a schizophrenic, cielothymic or mentally normal individual. In children especially the impression of outward appearance should always precede the history taking. An anemic, pasty, lymphatic child will influence our inquiries in certain directions.

The *stage of nutrition* should always be checked accurately. In making use of statistical weight charts or of length-weight indices one gets an objective control of the nutritional development. Of course one has to be careful in drawing conclusions from a state of undernourishment with regard to suspected pulmonary pathology. Yet it might help the diagnosis in the presence of other suspicions findings.

The *shape of the chest cage* itself sometimes shows marked predisposing peculiarities. The narrow, paralytic chest, the barrel shaped formation, all may have valuable bearing on the diagnosis of any present trouble. However, it is hard to say how much stress we ought to lay on the outside appearance of the body and chest in special and on the constitutional predisposing factors as their actual value is more or less problematical at present. This part of the examination should never give more than a hint which might be disregarded as soon as the further phases fail to reveal anything positive.

IMPORTANCE OF HISTORY

In taking the history of an apparently healthy person one may be able to recall to his mind long forgotten facts of great importance. *Heredity and contact* have to be elucidated by way of family history. There is no question that cases of tuberculosis in near surroundings are apt to strengthen one's suspicion. However, one may encounter off and on descendants from tuberculous parents, who although being infected, never in their life develop the disease to a clinically noticeable point.

The history of *repeated respiratory troubles in the past* must not necessarily confirm the suspicion of tuberculosis. It always should be borne in mind that measles, whooping cough, influenza and syphilis are the chief causes of chronic pulmonary infiltration in addition to tuberculosis. Accordingly we have not to neglect, but also not to overestimate the verbal information we are receiving from the health client.

PHYSICAL DIAGNOSIS

"The data obtained on percussion and auscultation of the lungs of normal children show wide variation from a fixed standard. These variations are usual and are considered to be within the normal limits. * * * Failure properly to evaluate these deviations from a fixed standard will often lead to the unwarranted diagnosis of disease and to even less justifiable treatment." This is part of a statement issued by a committee especially appointed by the National Tuberculosis Association for the express purpose of studying the clinical and roentgenological findings in the chests of normal children[1]. We do not have a more clear and more authoritative advice that only the most scrupulous way in evaluating physical chest findings will protect the physician and the client from misleading judgments. To base a diagnosis of tuberculosis on a certain deviation from the presumably normal or not to relieve the person from

a suspicion based solely on physical diagnosis would often lead to regrettable consequences. What the client is looking for is not any information on the absence or presence of suspicious physical findings but certainty about his own health or disease.

There are of course the well known signs more or less typical for chest diseases, for instance, persistent moist rales on coughing above the third rib, which usually will permit a diagnosis of tuberculosis beyond any doubt. However, there are many signs which cannot be taken as more than a suggestion, like interscapular dullness, d'Espine sign in children, modified breath sounds at the hilum, occasional crepitant rales at the upper lobe and more constant rales at the lower half of the chest. In these cases one always must realize the duty to investigate further by other means.

X-RAY EXAMINATION

The most important addition to the methods of auscultation and percussion is the x-ray examination, its value being so much greater the more one is uncertain of other findings. A most gratifying survey of the relative value of the roentgen ray and physical signs in the diagnosis and treatment of pulmonary tuberculosis has just been published from the U. S. Veteran's Hospital at Livermore, California[2].

From a study of 411 supposedly tuberculous cases the following results are published. Only 60 per cent of the cases were proven to be tuberculous. Cases without any physical findings but with positive roentgen lesions showed in 53 per cent positive sputum. Physical signs without the parenchymal x-ray lesion are of very doubtful significance, for all those cases had negative sputum. Peri-bronchial infiltration as seen by the roentgen rays, is of no importance in diagnosing pulmonary tuberculosis, as it was not found in any case in combination with positive sputum. Parenchymal infiltration as seen by the x-ray was in 68 per cent combined with positive sputum. The x-ray more often presents a great involvement than is shown by the physical signs.

I do not think that anyone, used to control his physical findings by x-ray as a routine, will come to a different opinion. There are of course also deviations from the standard x-ray plate of the chest to be found which are to be considered well within the range of normalcy. Increased hilum density, slight calcifications, peri-bronchial infiltration, if found, should never be used to confirm physical findings of similar vagueness. The small percentage of incipient cases where the x-ray plate has proven to be inferior to the physical examination could certainly never form an objection to its regular usage. Never should it be omitted to add accuracy to mere guessing by means of the x-ray technique.

LABORATORY METHODS

There is another question upon which there is no full agreement yet, as to what extent the health examiner should make use of laboratory methods. The opinion seems to prevail that in complicating a simple health survey by all kinds of scientific paraphernalia there is a danger of getting more figures and less results. Yet that applies only to the indiscriminate use of laboratory tests without a special plan. For instance, it would be poor judgment to omit repeated *sputum examinations* in a suspect for incipient tuberculosis or even in a case of supposed chronic bronchitis. Every adult complaining about raising sputum, as many older people are doing, especially in the morning, ought to have their expectoration examined sometimes, even if they should be free from any other trouble.

In children suspected of hidden tuberculosis infection the *tuberculin tests* are very often the only way to settle or to eliminate the diagnosis. The following data which have been obtained from a *review of 128 children at Muirdale Sanatorium* give an illustration of how insignificant the difference might be quite often between tuberculin reactors and non-reactors, as far as history, clinical, physical and x-ray signs are concerned.

The group has been divided by repeated tuberculin tests, the decisive dose being 0.001 gr. intradermally, in 67 tuberculin reactors and 61 non-reactors and therefore free from TB. infection. In comparing the TB. group with the non-TB. group with regard to all the different clinical criteria, we found the following figures. History of contact: TB., 58 per cent, non-TB., 0 per cent; history of repeated respiratory diseases in the past: TB., 47 per cent, non-TB., 59 per cent; pathological chest findings: TB., 23 per cent, non-TB., 35 per cent; general or local adenitis: TB., 69 per cent, non-TB., 74 per cent; d'Espine sign: TB., 47 per cent, non-TB., 25 per cent; anemia or

under-nutrition: TB., 51 per cent, non-TB., 71 per cent; sub-febrile temperature: TB., 85 per cent, non-TB., 80 per cent.

The specific X-ray findings in both groups gave the following figures. Increased hilum shadows: TB., 95 per cent, non-TB., 94 per cent; peri-bronchial infiltration: TB., 80 per cent, non-TB., 77 per cent; enlarged intra-thoracic glands: TB., 44 per cent, non-TB., 35 per cent; calcifications as shown by density of shadow: TB., 85 per cent, non-TB., 82 per cent; parenchymal infiltration: TB., 10 per cent, non-TB., 15 per cent.

The above statistics emphasize the obligation to use the only reliable biologic methods for diagnosis we have where the infection has not yet exceeded the merely biologic stage of a minute primary focus. A non-tuberculous child, whose general resistance might be reduced by other factors should never be permitted to be confined in a ward together with frank tuberculous cases. That would be directly opposite of prevention. Also in questionable tuberculous infection of adults the use of tuberculin tests should be considered, as the percentage of definitely negative reactors among the grown up persons is not negligible, especially in smaller towns or in cities with better hygienic housing conditions. *Being able for a certainty to rule out a suspected tuberculous infection is one of the greatest services the physician can render to his client.*

It should never be forgotten to obtain a *Wassermann test* on any person under observation. The possibility of luetic pulmonary lesions is not yet sufficiently realized, and the blood test might elucidate all of a sudden a puzzling case of apparent tuberculosis with persistently negative sputum.

Finally I should like to lay stress on a more recent laboratory test, the method of examining the *sedimentation rate of the blood corpuscles.* This test is not specific for any definite infection. The sedimentation of citrated blood, which in normal cases takes place at a constantly slow rate, is more or less increased by all kinds of infection or better by reason of disintegration of tissue cells. We therefore hardly will be able to make a differential diagnosis between tuberculosis and other infectious respiratory diseases, although as a rule an active tuberculosis will speed up the sedimentation rate more than most any other pathologic condition. Yet *the value of this simple test just for health examinations lies in the possibility of ruling out with almost certainty the presence of active tuberculosis.* I therefore do not see any appreciable objection to adopting this test as a routine procedure in health examinations.

CONCLUSION

In outlining the policy of periodical chest examinations in apparently healthy people we might say that the aim should be to establish certainty where there has been suspicion or likelihood of disease. *First there must be a propaganda for the purpose of inducing the people to make use of the health clinic or of health consultations with their private physicians. But at the end of the examination the client has the right to be relieved from any suspicion and any guessing and to be told in good faith about his actual condition.* I do not agree at all with the following sentence contained in the official booklet on periodical examinations[3]. "It is usually safe to regard a doubtful case, with suspicious signs, as tuberculous, so that the suspected patient may be treated by sufficient rest, fresh air and diet as he would be if a diagnosis were definitely established." If it only would be the matter of rest, fresh air and diet after pronouncing the diagnosis of tuberculosis, everything would be all right—but to condemn a person coming to his physician full of confidence, to the verdict of tuberculosis, with all the consequences to the family life and the professional career, the psychic effect, the result of probable contamination with other actually tuberculous persons; all that in view that it is possible to rule out the suspicion by a more conscientious and painstaking method of examination, would mean to discredit the new idea of periodical health examination. Exaggeration never is the proper method of impressing the public especially in the matter of health or disease. *Only the highest level of exactitude and true information will serve the purpose of the early prevention of chest diseases.*

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THE JOURNAL CLINIC

Diagnostic Problems

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In last month's problem we had a man 53 years old who had a sudden attack of violent pain over the heart one night while in bed. Following that he had loss of weight and dyspnea on least exertion, rapid heart without edema of the legs.

DISCUSSION

Violent pain of a peculiar stabbing or vise-like character beneath the sternum is the most important symptom of the complex called angina pectoris. The angina pectoris of effort, which takes a man suddenly while he is walking or exercising, stops him in his tracks and produces violent precardial pain with the curious sensation of impending death, is not necessarily concerned with any pathological change in the coronary arteries or in the aorta just above the valves. The anginal attack which comes on while a man is sitting quietly, lasts for hours or days and leaves the man with a heart rapid and easily fatigued, is the result of some definite lesion in the coronary artery, almost invariably arteriosclerosis.

This man when he was first seen apparently came in for some mild complaint which, however, even at that time, might have been the beginning of the process which he developed later. For months before a violent attack of angina pectoris there is discomfort and pain in the chest which does not come on following exertion but which strikes a man at odd moments. Such aches and discomforts are only of moment when they occur in individuals over forty-five years of age. All aches and pains which occur over the heart area in young people can be set down as neurotic except in the unusual case. This man is just in the age of thrombosis. He had a characteristic pain which was scarcely relieved by large doses of morphine and the attack was followed by evidence of profound cardiac weakness. This is not surprising when one remembers that the coronary artery at once cuts off the blood supply of a fairly large area of the ventricle, usually the left, softening of the muscle takes place and a scar is the result. This scar may be so large as to take in the lower part of the septum and the whole of the apex of the left ventricle. Under such conditions the heart is necessarily weak and the slightest amount of exertion brings on distressing shortness of breath. Swelling of the feet does not occur until later, as a rule, because of the fact that the left ventricle is the side of the heart which is weak and the blood is dammed back upon the lesser circulation and not upon the systemic circulation as is the case when the right side of the heart fails. This, then, is considered to be a typical case of thrombosis of the coronary artery occurring in a man of the age at which this accident usually takes place. He now has myocardial insufficiency which is the result of the serious injury to his heart muscle.

The important point about treatment in this condition is that nitro-glycerine has little or no effect on the acute attack. Morphine is the only drug which is of any value and it must be given in large doses. It is important to keep the patient in bed for weeks or even months, letting him get up very gradually and protecting his circulation in every possible way.

These cases are unfortunately quite common and an early recognition of the condition and proper treatment will undoubtedly prolong the lives of some of these victims.

A NEW PROBLEM

A young girl of English parentage, 19 years old, unmarried, complained of attacks of jaundice and of bloody urine. So far as she knows no member of the family had ever had any such attacks and there was no chronic disease in any member of the family. She passed through her childhood with no serious illnesses except for the usual children's diseases. She menstruated when she was fourteen years of age and her periods have always been regular, of normal duration, and painless. Since her menstruation it has been noted that she has had sudden attacks in which she passed blood in the urine and her eyeballs became distinctly jaundiced. When she takes medicine containing iron the bloody urine is brought on. This was con-

firmed. In England she was cystoscoped twice, but no lesions of any kind could be found. Her sister thinks that her skin is always just a little yellow. The attacks come on at irregular intervals, sometimes about a year apart and in at least one attack in 1925, she became so anemic that her hemoglobin was down as low as 30 per cent, and she suffered with fainting spells. However, she does not lose in weight when she has these attacks. In August, 1925, her blood count was: Hemoglobin, 34 per cent; red cells, 2,140,000; white cells, 3,400. The differential count was: polys., 48 per cent; small lymphocytes, 4 per cent; large lymphocytes, 17 per cent; transitionals, 4 per cent; large mononuclears, 1 per cent. The patient insists that when she has these attacks the urine she passes the first thing in the morning is bloody and then toward afternoon is gradually becomes clearer so that by evening the urine looks perfectly clear. In November, 1926, she had another attack, the blood showing practically the same picture except that the polys. were 80 per cent. The platelets at that time seemed greatly decreased and slight anisocytosis and pokilocytosis were present. She had at that time an abscess from an infected tooth which was opened. She was in such poor condition that she received three transfusions. This rapidly increased her hemoglobin and she left the hospital shortly afterwards. On or about January 7th, 1927, she had another attack. The urine which was passed in the morning and which was brought to me for examination was the most perfect port wine color that one could imagine. It was a typical hemoglobinuria. Another specimen brought to me passed about noon showed only a very slight tinge of blood; except for a small amount of albumin there was nothing in the urine. The centrifuged specimens were quite negative.

On examination she was a small but well nourished, intelligent girl. Her pupils were equal and reacted normally. There was no enlargement of the thyroid. Except for a short systolic at the pulmonary area of the heart, the chest organs were all negative. The pulse was rapid, 96 to the minute, but regular. The patient says that her pulse has always been a little rapid. The abdomen was natural in appearance with a normal amount of fat. The spleen was easily felt with a firm, round edge. The liver dullness was not increased. The liver edge was not felt and there was no pain anywhere on palpation of the abdomen. The right kidney was palpable but seemed quite normal in size. All the reflexes were present and normal.

She was sent up to the laboratory for some further blood examinations. The van den Bergh direct test was negative. The indirect test was positive and the red cells showed hemolysis between .36 and .42 per cent saline solution.

The discussion of this case with the probable diagnosis and recommended course of treatment will appear in next month's Journal.

Multiple Serositis; A Case With Generalized Anasarca

BY J. A. BIGLER, M.D.
La Crosse

This case is of special interest as to diagnosis because of the distribution of the fluid in the serous cavities and the anasarca present.

Male, age 29, father living and well, age 70; mother died at age of 60 of carcinoma of the stomach. Ten brothers and sisters, living and well. Patient sent to Mendota as a mental case nine months before admission to hospital.

PRESENT COMPLAINT

Stomach trouble, difficulty in breathing and swelling of extremities. Due to his mental condition, history is rather unreliable. Up to a year ago he worked as a laborer but would get irritable spells for which he was sent to Mendota. Remained in good health there until three months ago when he had an epileptic stroke while at dinner. For the next two or three weeks he received hypodermic injections every day. Does not know what kind or the reason. It was at this time that he began to notice a swelling of his neck and right arm. He also had bloody sputum for a week at this time. Since then the swelling of his body and extremities, and the shortness of breath has been growing progressively worse. No history can be elicited or previous lung disease, rheumatism, sore throats, or pains in mediastinum. Stomach trouble present for past sixteen years, has been constipated and feeling of fullness more marked at some times than others. No history of abdominal swelling can be elicited.

PHYSICAL EXAMINATION

Patient well developed male about thirty years of age, acutely ill, in semi-sitting position in bed. Very dyspnoeic and talking requires marked effort. Mental appearance below normal as evinced by unintelligent facial expression and small flat head.

Head—Small; eyes prominent, pupils equal and dilated, but react slowly to light and accommodation.

Teeth—Negative.

Neck—Normal except for some oedema, left side.

Chest—Large in appearance, oedema of left side more pronounced in axillary line and over back. Patient lies partly to left side, as he seems to be more comfortable this way. Expansion very poor with breathing rapid and labored. Lungs—right side resonant throughout; left only over upper lobe, the lower lobe being flat throughout, and excursion cannot be demonstrated. Dullness in left lung changes with change in position of patient signifying fluid. No Broadbent's sign present. Percussion of left chest difficult because of anasarca of tissues. Auscultation—breath sounds fairly clear on right side with some moist rales throughout, especially over base. Left upper lobe, some rales; no sounds over lower portion of lung.

Heart—No apex beat can be seen or felt. On percussion it is very difficult to ascertain borders because of anasarca of tissues and flatness of left chest, but it is thought, left border just outside left nipple line and right border just right of right sternal margin. Heart sounds very faint and irregular; no audible murmurs.

Abdomen—Large with generalized anasarca of tissues, most pronounced on left side. Ascites present but moderate. Liver palpable, smooth about three fingers below costal margin and somewhat tender. No enlarged veins in skin.

Genitals—Marked oedema of scrotum and prepuce.

Extremities—Marked oedema left arm and hand; right seems normal. Both legs and feet markedly oedematous. Knee jerks positive and equal.

B. P.—Right 96/70—Left 108/74. Hard to get left radial pulse due to much swelling of wrist. Right pulse also irregular but much stronger.

Fluoroscopy Examination—Right lung fairly clear, except at base; left, dense shadow over lower lobe which is demonstrated as fluid by changes in level. Left margin of heart cannot be made out, but right does not extend beyond right sternal margin, which is a very important finding.

Laboratory—W. B. C. 9,200. Urine, repeated examinations, yellow to amber color, acid, specific gravity 10:15 to 10:30; albumin trace on one occasion; microscopic, only a few hyaline casts present. Functional test 100 c.c. first collection 25%; second collection 50 c.c., 25%. Wassermann reaction negative. Aspirated fluid from chest—straw colored, clear, and contains no organisms, red or white blood cells. Slight amount of albumin present; cultures, negative.

Clinical—Temperature first two days up to 101°, after that occasionally to 99°. Pulse irregular and varies from 70 to 100. The day after admission left chest aspirated and 1300 c.c. of fluid obtained, the first being clear, straw colored and then bloody, due undoubtedly to puncturing of pleural vessel. Patient much more comfortable after aspiration. Upon third day in hospital, again showed respiratory embarrassments as left chest was again filled with fluid. Oedema of body and legs began increasing and urinary output continued very low. He had two attacks of coma, with Cheyne-Stokes respiration and marked cyanosis. Heart tones not audible—right pulse just palpable, irregular, with countable rate of 80. First attack occurred after one-fourth gr. morphine hypodermatically on ninth day in hospital and lasted about five hours. Second attack on tenth day, without receiving morphine, and terminated in death after four hours.

This case was at first thought to be on an ordinary cardio-renal basis, but the symptoms and physical findings did not coincide closely enough. The urinary findings did not warrant the amount of oedema present. The heart did not seem large enough to warrant the apparent decompensation and polyscrositis present. A cirrhosis could explain the fluid in the abdomen, but not all the other oedema and serositis and there were no enlarged veins. A tuberculous peritonitis or pleuritis would not have explained such an extensive involvement. Syphilis in the light of the negative Wassermann was ruled out. Malignancy was ruled out due to the patient's age and the dissemination of the oedema and serositis and absence of cachexia. Our other possibility was a multiple serositis (Pick's Disease). The first clue was furnished definitely by fluoroscopy when so much fluid was found in the left chest and yet the heart was not displaced to the right. This indicated pericardial adhesions, and the possible presence of a pericarditis. If the adhesions were strong enough to hold the heart in its normal position, then there might be pressure from the pericarditis upon the easily compressible veins entering the heart, causing a venous stasis and the uneven distribution of the oedema. No explanat[illegible] the difference in blood pressure of the two arms was found. There is nothing in the inadequate history which would lead one to suspect a mediastinitis or a pericarditis but when the physical findings and symptoms are taken into consideration and the pericardial adhesions, as demonstrated with the fluoroscope are noted, pericarditis, with extension to the pleura, causing a pleuritis would explain the fluid in the left chest —and a hepatitis, the fluid in the abdominal cavity. [illegible] provisional diagnosis of Myocardial Insufficiency and Pick's Disease was then made.

AUTOPSY FINDINGS

Marked anasarca of trunk and neck tissues, cyanosis of head and neck, with oedema of left arm, genitals and both legs and feet. Regular midline incision from neck to symphysis. Tissues markedly infiltrated with fluid. About 1000 cc of straw colored fluid in abdominal cavity, lower border of liver five fingers' breadth below costal margin, firm and smooth. Some adhesions between liver and diaphragm and perihepatitis present although not marked. No gross changes upon sec[illegible] of liver except congestion. Spleen slightly enlarged. No gross changes in kidneys or gastro-intestinal tract, except passive congestion. Upon opening chest, left thoracic cavity contained about 2000 cc of sanguinous fluid with partial collapse of left lung. Right chest cavity contained about 200 cc of straw colored fluid. Marked oedema of both lower lobes, no gross evidence of tuberculosis or pneumonia. Pleura was roughened but no adhesions to chest wall.

Heart—Normal in size and location. Pericardium covered with fatty tissue, with thick adhesions to the diaphragm. Upon trying to open the pericardial sac, it was found to be completely obliterated and the pericardium in turn adherent to the myocardium so that separation was impossible except by dissection. The pericardium was 2 cm in thickness and of the consistency of shoe leather. Contained no calcified plaques. Heart valves were not diseased and no calcium plaques in aorta. No evidence of syphilis. Dense adhesions were also found between the pericardium, mediastium and adjacent pleura. Where the pericardium encircled the blood vessels to and from the heart, there were thick non-elastic rings causing constrictions of the vessels.

ANATOMIC DIAGNOSIS

Adhesive paricarditis with myocarditis; perihepatitis with ascites; pleuritis with pleural effusion; chronic passive congestion of lungs, liver, kidneys, and gastro-intestinal tract; and generalized anascara and oedema.

We have here then the symptoms complex of a Pick's Disease (Polyserositis) as borne out by the pericarditis, pleuritis and perihepatitis. It is complicated by a myocardial decompensation due to the tight inelastic pericardial sac enclosing the heart with compression of the large vessels which in turn caused the generalized anasarca and oedema.

Cardiospasm: Report of a Case in a Boy of Twelve*

BY STANLEY J. SEEGER, M.D.
Milwaukee

J. N.; male; age 12, Milwaukee Children's Hospital, No. 16012, was admitted to the out-patient department of the hospital on May 1st, 1926, with a three-year history of dysphagia, regurgitation, pain in the chest, occasional difficulty in breathing, and loss in weight, his symptoms having gradually become worse. There was no difference in his ability to swallow either water or solids, although sometimes small amounts of water seemed to give him no trouble. Regurgitation of food occurred as a rule soon after swallowing, although at times he brought up food several hours after he had eaten it. The food regurgitated was never sour. Pain in the lower chest and difficulty in breathing had been more prominent in the past year, and occurred after the ingestion of food.

His weight on admission was 63½ pounds, and his height 58 inches. The normal weight for his age and height is 85 pounds.

Physical examination was essentially negative except for marked emaciation. X-ray examination showed a definite obstruction at the lower end of the esophagus. The line of obstruction was sharp; no irregularity or thread of barium could be detected below the beginning of the obstruction, and there was moderate dilatation of the esophagus. One hour after the ingestion of the barium meal the esophagus still contained a large amount of barium. It was empty at 4 hours. A number 43 olive was passed on a thread guide, and it encountered little obstruction at the entrance to the stomach. On June 4th, Plummer's hydrostatic dilator was inserted with the patient under ether anesthesia and 20 pounds of pressure applied. Immediately after dilatation, he had some epigastric pain which was not severe, and he was able to swallow liquids and solids without difficulty. On June 28th, he had gained 7 pounds in weight, and stated that he had slight difficulty in swallowing at times, but that he felt that his condition was satisfactory. On October 16th, 4 months after dilatation, he had

1. Photograph of Patient Before Dilatation.

*From Milwaukee Children's Hospital.

gained 20 pounds in weight, had no dysphagia for either solids or liquids, and felt that he was entirely cured. X-ray showed no obstruction at the cardia.

DISCUSSION

Cardiospasm is rare in infancy and is not commonly encountered during childhood. Cases in which cardiospasm occurred at 3 months and at 4 months were reported separately by Beck and Göppert, and Bruce reported a case at 3 years. These authors are quoted by Abt in his System of Pediatrics. Vinson, of the Mayo Clinic, writing in 1924, reported 87 patients, 15 and younger, who had difficulty in swallowing; 13 of these had cardiospasm; 6 congenital stricture; 61 a cicatrix, and in one the cause of the dysphagia was not determined.

II. Photograph of Patient 4 Months Following Dilatation.

There is some question as to whether this condition is an idiopathic dilatation of the esophagus, or a spasm of the lower end of the esophagus. However, cardiospasm is the term most commonly employed. Vinson, following Plummer's teaching, divides patients with cardiospasm into two groups: Group 1—those with a slight sense of obstruction at the cardia to the passage of food, with or without pain, but with no x-ray evidence of obstruction to the passage of barium mixture. These patients frequently have some psycho-neurosis and some require forcible dilatation in order to relieve symptoms. Many of the patients in this group are relieved by the use of anti-spasmodic drugs. This

III. Lateral View of the Esophagus 15 Minutes Following the Ingestion of Barium Meal.

IV. Antero-Posterior View of the Esophagus 15 Minutes After the Ingestion of the Barium Meal.

V. Esophagus 1 hour after the ingestion of Barium Meal. Roentgenograms show the definite obstruction at the cardiac orifice and dilatation of the esophagus. The obstruction is clean-cut, and the esophagus does not show any deformity or narrowing below the point of obstruction.

condition is sometimes secondary to gall bladder disease, and may simulate the globus of hysteria. Patients in Group 2 are those with definite obstruction. As a rule medical measures are of little value in treating patients in this group. Both sexes are equally affected.

The three principal symptoms of this condition are dysphagia, pain and regurgitation of food. Regurgitation is usually immediate but may be late, and very often occurs at night. It depends not only on the quantity of food taken, but on the degree of dilatation of the esophagus. There may be some fermentation of the food present, due to changes which have taken place in the esophagus. It is characteristic that the regurgitated food is not sour. Solids sometimes seem to pass more easily than liquids, and water alone, especially when cold, frequently cannot be swallowed. Respiratory symptoms are not uncommon. Pain is a variable symptom, but frequently follows immediately on the ingestion of food and occurs in the epigastrium. Nutritional disturbances are proportional to the degree of obstruction and may be very pronounced.

In the differential diagnosis one must consider carcinoma, diverticulum of the lower end of the esophagus, hernia of the stomach through the diaphragm or diverticulum of the cardiac end of the stomach, and also benign strictures. In infants, one must also consider rumination and pylorospasm or pyloric stenosis.

A diagnosis of cardiospasm can be made on the symptoms and the typical x-ray findings, which consist of obstruction at the cardiac orifice, with dilatation of the esophagus above this point. Another important diagnostic point is obtained by guiding into the stomach a 45-F olive on a previously swallowed thread. In obstruction due to cardiospasm this can usually be accomplished without difficulty.

Antispasmodic drugs and mechanical dilatation of the cardia constitute the principal methods of treatment. Atropin, either alone or in combination with benzol benzoate, has been the drug chiefly relied upon, when the former method of treatment has been employed. Where definite obstruction exists, dilatation is the best method, and this is best effected by Plummer's hydro-static dilator.

The results of dilatation when properly done are remarkable, patients being able to eat food of any type immediately without discomfort. Vinson reports 25 per cent of recurrences, which recurrences are usually noted within the first six months after treatment.

Fat Embolism; Case Report*

BY R. E. BURNS, M.D.
Madison

I. V. R., a single white woman, aged 22, was admitted to the hospital on May 19th, 1924, because of a residual poliomyelitis. The acute illness, which had left both lower extremities badly paralyzed, had occurred at eight years of age. Following this, she remained in bed for one year. Some muscular power gradually returned so that she was finally able to get about the home by crawling on hands and knees.

On admission to the hospital, there was nothing of importance in the general physical examination except that the patient was very obese and that the reflexes were absent in the lower extremities. She was unable to walk even with assistance, because of muscular weakness, marked flexion contracture at hips and knees, together with partial subluxation

*From the Orthopedic Service—Wisconsin General Hospital.

at the knees and paralytic equino varus (club feet).

The recommendation for treatment was as follows. Double Soutter fasciotomy for the correction of hip flexion deformity; gradual correction of the flexion deformity at the knees with plaster of Paris; stabilization of both feet by means of Hoke's operation and long leg braces.

The correction of deformity at hips and knees was accomplished. When the time arrived for correction of the deformity of the feet, the patient, whose morale and cooperation had always been poor, refused any further operative treatment. Braces could not be applied because the feet could not be put into shoes. To suspend treatment entirely would have been an invitation to certain recurrence of deformity. As an alternative procedure, a manipulation of the feet under anesthesia was advised in order to correct deformity sufficiently so that the patient could wear braces.

The manipulation of the feet was done at 10:00 A. M., on November 10th, 1924. At 4:00 o'clock in the afternoon, the patient's temperature was 101, pulse 120, respiration 22, but she seemed in good condition. She coughed a little and expectorated some mucus during the night. The next morning temperature was 100, pulse 140 and respiration 28. Some cough continued, and at noon there was a hurry call to see the patient, who had suddenly become seriously ill. She was irrational, recognized no one, then became drowsy. There was definite cyanosis, pulse 140, respiration 40 and temperature 101. There were numerous petechiae over the chest, a flush on the left cheek, dullness in the lower left chest anteriorly with hyper-resonance above. Breath sounds over the area of dullness were bronchial in type, with fine crackling rales coming in showers at the end of inspiration. A white blood count showed a leucocytosis of 22,400. The diagnosis was pulmonary embolism. She was given morphin sulphate gr. $\frac{1}{6}$, atropin sulphate gr. $\frac{1}{150}$, and digalen m XV hypodermically every four hours. She was also given glucose 5% by proctoclysis.

The next morning, November 12th, 1924, there was a definite paralysis of the facial nerve on the right side; there was an audible friction rub on the left chest at the post-axillary line (level of 5th and 6th ribs). The general condition of the patient was improved, especially the circulation. There were beginning herpes labialis.

Improvement was marked and continuous, and by the 15th, five days after the manipulation, she was practically well. Braces were applied, and she was discharged January 10th, 1925, walking with crutches. She returned to the hospital in October, 1926, for observation, and her condition was satisfactory.

The case is interesting because of the mode of embolic production, the symptoms and signs, the treatment and the recovery.

It has long been known that in poliomyelitis the bones become fragile, atrophic, and that the inorganic matter becomes decreased while the organic matter, mainly fat, becomes increased. It is also well known that prolonged immobilization in plaster of Paris produces the same condition in the bones. Both of these factors were present in the case under consideration. It is for these reasons that orthopedic surgeons have not undertaken forcible manipulation of atrophic bones without due reflection. Some fat embolism may occur wherever fat is traumatized in the body. The reason the condition is not diagnosed more often is probably because sufficient fat does not enter the blood stream to produce symptoms and signs, which the physician feels are definitely due to embolism.

In this case, pneumonia had to be considered in the differential diagnosis. A previous anesthetic, the increased pulse, respiration, temperature, herpes labialis, and chest findings would all fit into the picture of pneumonia.

However, a previous manipulation of atrophic bones, with the numerous petechiae, facial nerve palsy, sudden circulatory embarrassment coupled with the above signs and symptoms warrant a diagnosis of embolism.

It is not known how much credit for the patient's recovery should be given the treatment used. She might have recovered anyway. At the time the patient was at her worst, it was recalled that Riesman of Philadelphia was an advocate of morphin and atropin in pulmonary oedema. The mechanical conditions are much the same in the two conditions, and so the same treatment was instituted. Pulmonary embolism cannot continue for a long period without there being a pulmonary oedema also. Digitalis was added to the morphin and atropin in an effort to support a failing circulation. From the time treatment was begun, improvement was continuous and rapid.

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A. Departmental Officers of the State Board of Health. Address Dr. C. A. Harper, State Health Officer, State Capitol, Madison, Wis.

B. Clinicians of the Wisconsin Anti-Tuberculosis Association when in vicinity. Address Clinic Dept., W. A. T. A., 558 Jefferson Street, Milwaukee.

C. Councilors and Officers of the State Society. Address the individual.

2. *Annual Statements.* Uniform annual statements can be had without cost. Address the Secretary, advising number desired.

EDITORIALS

THIS CHANGING WORLD

DURING a recent visit with a small group of active surgeons to a large medical center for a week of intensive study, perhaps the most definite impression was that made by the contrast between such a visit a few years ago and the present one.

The change in point of view and broadening of the horizon of the surgeon might well serve as subject matter for one of the series of cartoons in the daily press entitled, "This Changing World."

Among the many changes between the old and the new, the following were noteworthy:

PAST	PRESENT
1. Attention was frequently centered upon the operator and the operation, in the operating theater.	1. Attention is now directed more to the disease and the patient, and less to the operator and the operation; and the operating room is less and less a theater.
2. A clinic usually consisted of a multiplicity of operations.	2. Clinics are now usually concerned with cases showing various phases of a single disease, or a group of related diseases; they are frequently "dry," or with few operations.
3. Technical details were emphasized and methods of operating were given much prominence.	3. Details and methods are replaced by generally accepted principles; the why and the when, to operate, and not to operate, are given much consideration.
4. As operations were usually for removal of advanced disease, or in emergencies, pre-operative and post-operative measures were overshadowed by the technical maneuvers.	4. As the majority of operations are now performed for early disease (often prophylactic) and for chronic disease, pre-operative and post-operative measures are given due consideration.
5. The benefits to be derived from physiotherapy and its various modifications were not appreciated.	5. Physiotherapy is used rationally and with marked benefit after many operations.
6. Gross pathology and histologic study were often considered to be academic.	6. Pathologic diagnosis is now routine and many deem it essential, in the choice of operation, and in the subsequent management of the case.
7. The immediate result was often the end of the record of cases and at times led to erroneous conclusions.	7. The remote result is carefully checked by "Follow-up" systems and aids in evaluating methods of treatment.
8. Ward rounds, staff conferences, and autopsy discussions were overshadowed by the operating theater. The surgeon rarely found time to visit medical wards unless in formal consultation.	8. Ward rounds, staff conferences, and autopsy discussions often attract more attention than does the operating room. The surgeon is anxious to visit the medical wards and other departments.
9. Surgical tuberculosis was common. Cancer was treated by excision or destruction by knife or cautery.	9. Tuberculosis calls for surgery less frequently. In certain clinics, and in certain organs, operation for cancer has been largely superseded by radium or x-ray.
10. Little, if any, attention was given to attempts to discover causes, or the natural history of various diseases, for instance in cancer, energies were directed to its removal or destruction.	10. Research institutes endeavoring to learn basic facts concerning cancer are increasing rapidly, as are similar institutions or foundations aiming at an increase of our knowledge concerning diseases of the blood, of metabolism, of tuberculosis, and of other pathologic conditions.

In early surgery, operation was for advanced disease or for emergencies, was usually a life saving measure and frequently was an end within itself. As the domain of surgery was extended to include so-called chronic diseases, interest in the remote result was forced upon the surgeon which has finally led to a condition in which pre-operative and post-operative management has been necessary, either by the surgeon or some one else, with a result that the operation is often merely an incident in the course of management of the disease; such management demands earnest cooperation between the various departments of "medicine."

—F. G. C.

THE WHY OF SUICIDES

NOW that we have heard from the pulpit and through the editorial columns of the press concerning the causes of a series of suicides among university students occurring of late, it might be appropriate to hear from those whose business it is to observe, study, and treat this class of individuals.

From the pulpit we find the explanation in the "gorging and forcing the mind before it is

mature," particularly with "speculative theories of psychology, sociology, and subjects which call for maturity of intellect for their mastery or comprehension." The press approaches the truth in defending our courses of study and emphasizing the "neurotic life of these piping days," and calling attention to the fact that the suicide rate among students falls considerably below that of the average of the general population.

All, however, have quite forgotten to take into consideration the individual equation. These individuals are emotionally unstable and are only exhibitions of "shell shock" in times of peace. We always have had and always will have them, and but for their early passing they would in all probability have developed a "mental state" under some subsequent mental strain. The emotionally unstable are ever subject to suggestion and the wide advertising of the "students' suicide parade" by the press serves only to increase the numbers. Most of these individuals were never intended for a student's life, and failed before they started. Some day there will be a more careful appraisal of physical and mental qualifications of those entering our industries, professions, and universities.—A. W. R.

USING THE LABORATORY

THE last fifty years have witnessed the development of laboratory procedures in such profusion and variety that there has been some fear of having the ancient diagnostic acuity of the medical profession overwhelmed by methods of precision. It is certain that no well-rounded physician will permit himself to neglect the established means of diagnosis by observation and the use of his six senses, including common sense.

On the other hand, there is some evidence that we are not making the most of laboratory methods which should be in every day use. One of these is the examination of sputum in respiratory infections, with tuberculosis prominently in mind. Figures submitted by the State Laboratory of Hygiene indicate that much greater use is made of the laboratory for the diagnosis of diphtheria than for the diagnosis of tuberculosis. The central laboratory reports a ratio of nine negative cultures to one positive and only five negative sputa to one positive. The Beloit laboratory reports 7 to 1 for diphtheria, 6 to 1 for tuberculosis. Green Bay reports 14 to 1 for diphtheria, 4 to 1 for tuberculosis; Kenosha 14 to 1 for diphtheria, 4 to 1 for tuberculosis; Oshkosh 8 to 1 for diphtheria, 3 to 1 for tuberculosis; Rhinelander 9 to 1 for diphtheria, 5 to 1 for tuberculosis; Wausau 7 to 1 for diphtheria, 3 to 1 for tuberculosis. Racine city laboratory reports 10 to 1 for diphtheria, 8 to 1 for tuberculosis. Superior alone shows 6 to 1 for diphtheria and a higher ratio, 7 to 1, for tuberculosis. The total of central and branch laboratories gives an 8 to 1 ratio for diphtheria and 4 to 1 for tuberculosis.

With the exception of the Superior branch laboratory and the Racine municipal laboratory there is a wide divergence between the ratios showing that diphtheria diagnosis by culture is much more frequently employed than is tuberculosis diagnosis by sputum examination.

In view of the fact that the death toll from tuberculosis is more important not only numerically but because of its occurrence in the prime of life, and particularly in view of the fact that we have specific cure and prevention for diphtheria while we lack these in tuberculosis, it would seem worth while for physicians to make more extensive use of the laboratory in the diagnosis of tuberculosis.—W. W. B.

PHYSICAL THERAPY AND PSEUDOPHYSICS

Much of the literature on physical therapy has apparently been written with an eye to the royalty statement or the publicity returns rather than to the possibility of scientific criticism. Aside from the questionable value attaching to the statements of clinical experience, these treatises become impressive, in size, at least, by the inclusion of statements on the physics of the apparatus culled almost in toto from the advertising and descriptive matter published by a manufacturer. This practice might be commendable if the physical concepts were not often wholly at variance with the concepts generally accepted by physicists. This wanton display of pathetic ignorance arises, no doubt, from a desire to make physical science conform to absurd, preconceived theories as to the biologic effect of physical energies. The physician who desires a substantial knowledge of physical therapy must choose his sources of information carefully. A recently published "Practice of Physiotherapy" teaches electrophysics to which physicists could not possibly subscribe. Some of the statements made indicate that the author has but an imperfect knowledge of Ohm's law, the fundamental and the most simple law of electricity. The belief that 20,000 volts will cause only one ampere to flow through the same resistance through which 2,000 volts forced a current of one ampere would be amusing if it did not give false conceptions of the physical laws on which the operation of physiotherapeutic apparatus is based.—*Jour. A. M. A.*, Jan. 15, 1927.

THE PRESIDENT'S PAGE

Arthur W. Rogers

THE MEDICAL PROFESSION AND THE PUBLIC

It would undoubtedly elicit a smile from the average individual to overhear the remark, "The medical profession is overly modest regarding its attainments." This smile might be justifiable if the statement were not developed.

It occurs to us that modesty is not the desired term, but more properly lack of vision.

It is truly remarkable how little knowledge the laymen possess concerning the activities of our profession and the tremendous amount of labor expended in their behalf. We meet those who have never heard of the A. M. A., who have no understanding of why we have a state organization, and who do not know who moulds legislation to protect their health.

Who is responsible for this? Our profession, and we have come to this realization almost too late. Our national, state and county societies have at last a concrete educational program; and in Wisconsin we are reaching nearly every newspaper in the state with properly edited articles, and the public is participating in the programs of many of our meetings. Some communities have a trained group of physicians who go where and when called to give popular addresses on medical subjects. A still broader innovation has been initiated in certain sections by admitting the laymen to medical societies as associate members. It appears that medical men have at last realized that a body of influential citizens can do much to aid the public in choosing wisely between the untrained, quack, and nostrum vender and the scientifically equipped physician.

The medical profession has no apologies to offer for its services to the public, and the sooner the public is acquainted with this fact and taken into our confidence the sooner will there be a better mutual understanding and cooperation.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

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Wood	J. C. Hayward, Marshfield	V. A. Mason, Marshfield.

SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

The members of the Brown-Kewaunee County Medical Society met at Hotel Northland, Green Bay, February 2nd.. The meeting was called to order by President Schmidt and the minutes of the preceding meeting were read and approved.

Drs. Minahan and Burdon presented two very interesting cases in conjunction with Dr. O. H. Foerster, Milwaukee, who presented a paper on "Common Diseases of the Skin and Their Treatment," illustrated by lantern slides. The meeting was well attended and adjourned at 10:45.—M. H. F.

COLUMBIA

Dr. Arthur W. Rogers, president of the State Society, addressed a meeting of the Columbia County Medical Society at the Emder House, Portage, on February 10th. A demonstration of the method of procedure in a complete physical examination of the apparently healthy individual was given by Dr. Oscar Lotz, of Milwaukee. A banquet preceded the presentation of the program.

—H. E. G.

DANE

The February meeting of the Dane County Medical Society was held at St. Mary's Hospital upon invitation of the staff. Dr. S. R. Boyce spoke on "The Management of Upper Respiratory Infection;" Dr. W. M. Nesbit, on "Bronchoscopy—With Demonstration of Technique"; and miscellaneous case demonstrations were presented by the resident staff of the hospital. Dr. W. F. Lorenz outlined the treatment for preeclampsia.

Following the scientific meeting, a buffet luncheon was served by the ladies of staff members. The meeting was attended by fifty-two members.—H. H. R.

FOND DU LAC

The Fond du Lac County Medical Society held its regular monthly meeting on February 17th at the Hotel Retlaw, Fond du Lac.

The society was addressed by Dr. C. W. Hopkins, Chicago, chief surgeon of the Chicago Northwestern Railway, on "Intracranial Injuries." There were sixty-five members present, including members from Brown, Kewaunee, Outagamie, Calumet, Dodge and Winnebago counties. Dr. Elliott of Fox Lake presented a clinical case of head injury in detail, with results, as the accident happened eighteen months ago. The paper was followed by a general discussion by the members present—H. R. S.

LA CROSSE

The last monthly meeting in 1926 of the La Crosse County Medical Society was held at the Pioneer Club December 16th. Preceding the meeting a dinner, followed by a musical program was enjoyed. The following officers were elected for the ensuing year: President, Dr. E. Smedal; vice-president, Dr. G. Gundersen; secretary-treasurer, Dr. N. P. Anderson; censor, for three years, Dr. D. S. MacArthur; delegate, for two years, Dr. Wm. E. Bannen, and alternate, Dr. E. E. Gallagher.

Dr. Frank C. Margoles was unanimously voted in as a member of this society, his transfer card having been approved by the censor.

The first monthly meeting in 1927 was held Wednesday evening, January 12th, at the Supervisor's room at the Court House. The following papers were heard and discussed by the members: "Legal Aspects of Medicine," Judge E. C. Higbee; "Carcinoma of the Appendix," Dr. C. A. Gehring; "Interesting Urological Conditions," Dr. Alf Gundersen.—N. P. A.

MARINETTE-FLORENCE

The Marinette-Florence County Medical Society held a dinner program Tuesday evening, February 15th. The talent came from the Wisconsin General Hospital, Madison, in the form of Dr. R. C. Buerki, Dr. John E. Gonce and Dr. R. L. McIntosh. Dr. Buerki presented an address on "Relation of the Hospital to the Medical Profession"; Dr. McIntosh gave a paper on "Dermatology" and Dr. Gonce discussed "Some of the Newer Methods of Treatment of Children."

The meeting was well attended, physicians being present from Menominee, Daggett and Powers, Michigan, and from Oconto and Wausaukee, Wisconsin. It was the consensus of opinion that it was one of our banner meetings.—M. D. B.

RACINE

The regular meeting of the Racine County Medical Society was held on February 17th at St. Mary's Hospital, Racine. Miss Cornelia Van Kooy, Milwaukee, President of the Wisconsin State Nurses' Association, gave an address on the subject of "Is there anything wrong with private duty nursing?"

Miss Juliet A. Whitteker, Director of the Nursing Service in Racine, under the auspices of the Red Cross Chapter, spoke on "Making Hourly Nursing Possible in Racine."—S. J.

ROCK

The Rock County Medical Society members, wives and guests, met at dinner and program in the new Y. M. C. A. Building, Janesville, on January 25th. Dr. B. F. Lounsbury, Chicago, chief surgeon for the Milwaukee road, was the principal speaker of the evening. He spoke on the subject of "Fractures."

Preceding the address the Janesville Telephone Company presented a short entertainment.—H. E. K.

SHAWANO

Dr. R. C. Cantwell, Shawano, was elected president of the Shawano County Medical Society at its annual meeting on Wednesday, February 9th. Dr. R. E. Van Schaick, Marion, was chosen vice-president; Dr. C. E. Stubenvoll, Shawano, secretary-treasurer, and Dr. A. J. Gates, of Tigerton, was elected delegate to the annual meeting at Eau Claire in September.—C. E. S.

WALWORTH

At the annual meeting of the Walworth County Medical Society held at Elkhorn, on December 22nd, the following officers were elected for 1927: Dr. B. J. Bill, Genoa City, president; Dr. C. A. Wright, Delavan,

vice-president; Dr. T. P. Keenan, Lake Geneva, secretary-treasurer, and Dr. E. J. Fucik, Williams Bay, delegate.—T. P. K.

MILWAUKEE ACADEMY

The members of the Milwaukee Academy of Medicine met on February 8th at the Medical Arts Building. Dr. B. H. Schlomovitz presented a paper on "Gastralgia in Tabetics Addicted to Morphine." A paper on "Carcinoma of the Penis" was presented by Drs. W. M. Kearns, T. L. Squier and O. Oesterlin. Dr. H. L. Kretschmer, Chicago, spoke on "Urological Problems in Infancy and Childhood."

The Pediatric, Oto-Ophthalmic, and Radiological Societies have contributed funds for the building up of their sections in the library. A gift of $120 per year has been made by the Neuro-Psychiatric Society in building up their section.

The meeting held on February 21st was in the nature of a joint meeting with the Milwaukee Pediatric Society. The following papers were presented: Dr. A. L. Kastner, "Intussusception"; Dr. E. Cushing-Lippitt and Dr. S. H. Lippitt, "Pyloric Stenosis"; Dr. A. B. Schwartz, "Roentgenologic Studies in Scurvy"; Dr. S. J. Seeger, "Cardiospasm"; Dr. M. G. Peterman, "A New Micro-Precipitation Test for Syphilis"; Dr. K. E. Kassowitz, "The action of Ultra Violet Radiation on the Bactericidal Property of the Blood"; and Dr. G. H. Fellman, "Pyloric Stenosis."—D. E. W. W.

MILWAUKEE OTO-OPHTHALMIC

The regular monthly meeting of the Milwaukee Oto-Ophthalmic Society was held Tuesday evening, February 15th, at the University Club. Dr. Robert Sonnenschein, Chicago, gave "A Resume of the Functional Testing of Hearing." His talk was augmented with lantern slides.

—E. R. R.

NEURO-PSYCHIATRIC

Dr. G. W. Hall, of Chicago, spoke before the Milwaukee Neuro-Psychiatric Society on January 27th. Dr. Hall's address was on the subject of "Nonspecific Protein Therapy in General Paresis."

Dr. Hall discussed the early history of protein treatment in general and then came down to the present-day progress, which naturally led to the work done by Wagner and Nonne in Germany on the treatment with malaria. Dr. Hall's work led him to try the killed typhoid bacillus as a protein, which treatment most closely resembled the same reactions obtained by the malaria injection. He further stated that he thought the benefit of the malaria treatment was due to the protein resulting from the malaria organism. The result of his preliminary work convinced him that the fever reaction from the typhoid could be regulated without producing any ill effects upon the patient. Several charts which he showed in cases which he reported were very convincing. He usually started with twenty-five or forty million doses given intravenously, and increased the dose twenty-five or fifty million every second day, producing some chill with a rise of from one to four degrees of temperature. This treatment was continued for a period of fifteen to eighteen injections. A study of the blood and spinal fluid was made before and after the treatment, and in most cases the cell count was markedly reduced, and the Gold sol or Lange reaction showed a marked reduction, so that in some cases after treatment one would not interpret the reading as that of a paretic curve.

One thing the protein treatment will do in most cases, is to make the blood Wassermann negative. There is never any anemia produced by this treatment. The leucocyte count usually runs up from twenty to thirty thousand, and the treatment can be continued indefinitely with no danger to the patient. I understood the doctor to say he secured his typhoid through the house of Lederle. The work has not progressed far enough to justify them in making any claim, but they are rightly enthusiastic with results thus far secured, and are continuing the treatment in this and other lines with hopes of more favorable results as they go on. It is certainly a treatment worth considering in any obstinate case of paresis which might come under the observation of any of us.—W. K.

UNIVERSITY OF WISCONSIN

At a meeting of the University of Wisconsin Medical Society, held on February 17th, the following papers were presented: "The Similarity Between Pulmonary Blastomycosis and Tuberculosis," Dr. E. B. Medlar; "The Development of Medical Ethics IV," Dr. C. D. Leake; "Practical Aspects of the Cancer Problem," Dr. Karl W. Doege.—C. D. L.

WISCONSIN UROLOGICAL SOCIETY

The following program will be presented at the Wisconsin Urological Society meeting, to be held at Milwaukee on Saturday, March 19th:

9:00—11:00 A. M. Dry Clinics at St. Joseph's Hospital, by Drs. A. J. Hood, Wm. M. Kearns, R. E. Stockinger.

3:00—5:00 P. M. Medical Arts Building: "Metastatic Carcinoma in the Ureter," by Dr. Wm. J. Carson; "Pathologic Problems in Urology," by Dr. Edward L. Miloslavich, Prof. of Pathology, Marquette Medical School; "Bipolar Diathermic Treatment of Bladder Papilloma," by Dr. A. G. Jenner; "Limitations of the Plain Radiogram in Urologic Diagnosis," by Dr. James C. Sargent.

Meeting at 6:30 (place to be announced later). "The Pathology and Pathogenesis of Non-Tuberculous Infections of the Kidney," by Dr. Hugh Cabot, Ann Arbor, Mich.

Note: All meetings are open to the profession at large and full attendance is invited. Those wishing reservations at the dinner meeting, please notify Dr. James C. Sargent.

NEWS ITEMS AND PERSONALS

Dr. Ralph M. Waters, Kansas City, Mo., has been appointed to the clinical staff of the Wisconsin General Hospital. He becomes assistant professor of surgery in charge of anesthesia.

Dr. Waters received his A.B. degree from Adelbert in 1907 and an M.D. degree from Western Reserve in 1912. He has devoted himself for a number of years to anesthetics as a specialty at Kansas City. He is a past president and a past secretary of the Mid-Western Association of Anesthetists.

Dr. C. M. Andrews moved to Scandinavia recently and will establish his practice in that village. The doctor is well known in that vicinity in that he practiced at Scandinavia before coming to Waupaca some ten years ago.

At a cost of two cents per child, ophthalmia neonatorum, or inflammation of the eyes of newborn children, the disease which formerly sent many to the school for the blind, has been made negligible, since it is seldom seen now in the state. This is shown by statistics evidencing that only thirteen cases of ophthalmia were reported to the State Board of Health in 1926, none of which, so far as known, resulted in blindness. In 1925 the total number was twenty-four.

Since 1909 the law has required prophylaxis of the eyes of infants at birth with silver nitrate. The State Board declares this causes no harm but effectually prevents infection. Since that year the board has annually supplied physicians, midwives and hospitals, free, with wax ampules of silver nitrate. The state outlay for this purchase formerly was $1,500 a year. The board made provision a year ago for manufacturing the preparation in the state laboratory at Madison, at a saving of about 40 per cent.

Statistics from institutions for care of the blind in twenty-six states show that from twenty-five to thirty per cent of these cases resulted from ophthalmia neonatorum. The statute imposes a fine of $100 for failure to administer or have the prophylaxis administered. All cases of ophthalmia must be reported within six hours to the health officer.

Schools throughout the country are requiring periodic physical examination not only as preventive and curative measures, but so that a proper inventory of physical and mental ability may be used to guide the child's efforts into channels where he can secure satisfactory results, Dr. Sarah I. Morris, of the University of Wisconsin department of student health, stated in an address before Wisconsin farmers and homemakers recently.

Without proper guidance of this nature, haphazard selection of vocations for which the child is unfitted only results in failures and more inefficiency through discouragement, Dr. Morris said. These children eventually become drifters if the tasks attempted are beyond their strength, and from the ranks of these misfits are recruited the mal-contents who swell our criminal class.

Word has been received of the passing on of Mrs. L. H. Hayman, wife of Dr. L. H. Hayman who practiced for more than thirty years at Boscobel. He subsequently moved to Pasadena, Calif., but continues to be a member of the Grant County Medical Society. The many professional friends of the doctor in southwestern Wisconsin tender to him their sympathy at this time.

Prof. E. M. Medlar, professor of pathology at the University of Wisconsin and assistant professor of pathology at the Wisconsin General Hospital, will sever his connections with both institutions at the end of the present academic year to accept a position with the Mount McGregor Sanitarium, New York, where he will devote full time to research work on tuberculosis.

The Mount McGregor Sanitarium is an institution of the Metropolitan Insurance Company. Dr. Medlar will make his home at Glen Falls, N. Y. He plans to leave Madison the latter part of June.

The death rate from cancer in Wisconsin—forty-two persons a week—would be greatly reduced if patients in the early stage of the disease would consult a physician, according to Dr. J. P. McMahon, who spoke at a meeting of the Home Economics Club in the Public Museum recently.

Dr. Victor F. Marshall, Appleton, attended clinics at New York City and Baltimore during the month of January and February with members of the Wisconsin Clinical Surgical Club.

A meeting of the physicians of Kaukauna was held recently at the office of the city nurses to formulate plans for medical examination of children attending the graded schools. The examination will include about 1,500 children and is the result of a request by the city nurse for medical inspection of the grades.

Tribute to the late Dr. Albert J. Ochsner marked the Memorial Service held by the Chicago Medical Society February fourth.

Dr. Walter W. Chipman of Montreal, president of the American College of Surgeons, Dr. William J. Mayo of Rochester, and Dr. Allen B. Kanavel, professor of surgery at Northwestern University, paid tribute to Dr. Ochsner as the "pathological surgeon."

In the beginning of operative surgery, Dr. Kanavel pointed out, absence of anesthetic made speed imperative. So the doctor who was the surest as to this knowledge of anatomy was reckoned the best surgeon.

With the development of anesthetics and asepsis it was no longer so important to know the precise anatomy as it was to be skilled in pathology, for greater time and safety is possible to search out diseased areas more persistently. And of these surgeons, skilled in pathology, Dr. Kanavel paid high tribute to Dr. Ochsner.

"But now," continued Dr. Kanavel, who was introduced as the spokesman for the younger men of medicine. "It is not sufficient simply to know pathology. One must be skilled in preventing pathological conditions. Now it is physiology and chemistry upon which surgery must be largely predicated."

Dr. Mayo, in his appraisal of the former chief of staff of Augustana hospital, listed as among the specific contributions Dr. Ochsner had made to the world of surgery the following:

Use of the cautery in burning away the diseased area in cancer.

First to emphasize the danger of generalized infection about the mouth.

Pioneer in advising against universally operating immediately in appendicitis cases.

"And," added Dr. Mayo, with a smile, "when he read a paper at a convention it was also to show the fellow who didn't know, something new; it was never to let the fellow who knew be impressed with Dr. Ochsner's learning."

Dr. N. V. Sandin, who has practiced in the city of Amery for the past ten years, has purchased the offices and practice of a physician at Maiden Rock. He will begin his work in that community at once.

Dr. J. F. Brown, former superintendent of the Central Hospital for the Criminal Insane at Waupun, has been appointed physician at the Wisconsin State Prison at that city. He returns to Wisconsin from St. Louis where he has resided for some time on account of ill health.

Dr. J. M. Dodd, of Ashland, was re-elected president of the board of directors of the Ashland General Hospital at their recent meeting.

Following the annual meeting of the State Board of Health at Madison recently, it was announced that Dr. Otho Fiedler, Sheboygan, had been re-elected president of the board.

Dr. Fiedler now begins his third year as president of the State Board of Health, having succeeded Dr. William F. Whyte, Watertown, in 1925, and having been re-elected last year. He has served as a member of the board for thirteen years. He was appointed to the state board of health during the term of Governor McGovern and reappointed by Governor Phillip.

Dr. Joseph Dean, Madison, was re-elected vice-president of the board.

Dr. Rodney J. Gray, newly licensed physician of this state, who has just completed his internship at the Wisconsin General Hospital, will move to Brooklyn in the very near future to establish his practice.

Dr. Edward L. Miloslavich, professor of Pathology at Marquette University School of Medicine, addressed the Ninth Councilor District Medical Society, at Marshfield, January 14th, on the subject of "The Importance of Post-Mortem Examinations for the Practitioner."

Dr. Dirk Bruins has resigned as physician at the Home for Dependent Children, Wauwatosa, after serving in that capacity for eleven years. He will devote his time to private practice.

A strong plea that ministers, teachers and other persons in touch with the public exert all means at their disposal to combat medical quackery, was voiced by Dr. Louis M. Warfield, Milwaukee, in a talk before members of the Professional Men's Club during January.

The greatest danger of quackery, he explained, lies in the fact that the pseudo-physicians get patients with curable diseases and then fuss about with them so long that the disease develops into an incurable one.

Dr. A. M. Rosenheimer, of Fox Lake, is spending the months of January, February and March in Florida. He resides at 108 South N St., Lake Worth.

Reviewing the work done in Janesville by the health department, Dr. Fred B. Welch, city health officer, addressed the Kiwanis Club in the Grand Hotel during February. Dr. Welch advocated the early building of a sanatorium in Rock County to take care of tuberculous patients.

Marked declines in deaths from scarlet fever, diphtheria, typhoid fever, smallpox, puerperal septicemia and enteritis in infants were features of the state's mortality record in 1926, given out by the State Board of Health.

Principal causes of death and their number in 1926 were: cancer, 2,978; pneumonia, 2,357; violence, 2,055; tuberculosis, 1,829; influenza, 987, enteritis under 2 years, 424; whooping cough, 158; diphtheria, 154; measles, 142; scarlet fever, 77; puerperal septicemia, 56; typhoid fever, 42.

Dr. John W. Coon, president of the Rotary Club at Stevens Point, addressed the members recently on the history of the anti-tuberculosis crusade in Wisconsin and the founding of River Pines Sanatorium.

"The specific germ causing tuberculosis, the tubercle bacillus, was discovered by Koch in 1882," said Dr. Coon. He explained that the first work done to fight the dreadful disease in Wisconsin was the forming of a tuberculosis commission in 1903 by the Milwaukee Medical Society. In 1903-1904 a bill was introduced into the state legislature by Judge J. C. Karel, providing for a state commission, which was approved by Governor La Follette. As a result of a survey made by this commission, the legislature appropriated $95,000 for a state sanatorium, which was built near Wales, being completed in 1907, one year after River Pines was built."

Dr. Morrell Bunch, for six years associated with the Milwaukee police and fire departments as a police surgeon, has tendered his resignation to Chief Jacob G. Laubenheimer of the police department.

Dr. E. A. Brzezinski, Milwaukee, was appointed by the chief to fill the vacancy.

Physicians of Beloit Clinic held the third of six medical-scientific meetings being conducted this winter, on Friday evening, February 11th. Dr. P. A. Fox presented a paper on "Endocrines and Their Relationship to Gynecology," which was followed by discussion.

The fourth meeting at the Clinic will be held on March 11th, when Dr. J. Clyde Smith will talk on "The Use of the Ophthalmoscope and the Significance of Retinal Pictures in Systemic Disease." The fifth will be held on March 25th and will be on "Diabetes"

and on "Blood Transfusions," by Dr. F. E. Brinckerhoff. The last session is scheduled for April 8th. Dr. H. E. Kasten will lead discussion on "The Urine Analysis, Its Utility and Limitations in the Diagnosis of Disease." The same night Dr. B. E. Wiley will talk on "Utility of Physiotherapy in Skin Diseases."

The first program was held December 17th, when Drs. H. M. Helm and C. N. Dawson spoke on "Blood Diseases." Dr. Benjamin Fosse spoke on "Abnormalities of the Thyroid" at the second meeting, held January 14th.

Any physician in Beloit is invited to attend, as well as physicians from surrounding communities.

Through the cooperation of the Sheboygan Women's Club with the Sheboygan County Medical Society, a method has been devised in which the kindergarten children of the public schools are to be examined regularly. Accordingly, eight physicians have volunteered their services to the work. The dental examinations have been previously instituted and so have the child welfare clinics, leaving the kindergarten supervision to fulfill the bill.

Dr. Leland Dietsch is now associated with Dr. E. B. Felter of Plymouth. Dr. Dietsch formerly practiced at Evanston, Ill.

Dr. H. O. Worthing, Sheboygan, suddenly stricken last fall while attending a Chicago football game, has now regained his health and is again in active practice.

Dr. A. A. Hoyer, Beaver Dam, has just moved into his new offices at 124½ Front Street. His quarters consist of an x-ray room, examining room, waiting room, private office, and laboratory.

Members of the staff of St. Michael's hospital, Stevens Point, have turned in pledges to the hospital campaign fund aggregating $10,500. The action of the physicians is a striking testimonial to their interest in the project. Their combined contributions amount to more than one-tenth of the minimum amount required by public subscription to erect the proposed new addition.

The members of the staff who contributed to the fund are: Drs. W. F. Cowan, D. S. Rice, C. von Neupert, Erich Wisiol, G. H. Lawrence, F. R. Krembs, L. D. Cutting, R. C. Lowe, W. W. Gregory, E. P. Crosby and F. A. Marrs.

Dr. and Mrs. M. D. Bird entertained at dinner recently the physicians in the city of Marinette, together with their wives.

Dr. H. H. Milbee, of the Marshfield Clinic, Marshfield, will devote an entire month to post-graduate study at the University of Toronto, Canada. Before returning to Marshfield, Dr. Milbee will also visit his parents who reside at Barrie, Ontario.

At the Eighteenth Annual Meeting of the Minneapolis, St. Paul & Sault Ste. Marie Railway Surgical Association held at Radisson Hotel, Minneapolis, on February 25th and 26th, ten Wisconsin physicians presented papers. They include: "Cleanliness in Emergency Surgery," Dr. Carl von Neupert, Stevens Point; "Relation of Dental Sepsis to Diseases of the Eye," Dr. Richard C. Smith, Superior; "Surgical Care of Jaw Fractures," Dr. M. N. Federspiel, Milwaukee; "Concealed Traumatic Infection," Dr. Reginald L. Prees, North Fond du Lac; "Report on a Case of Irreducible Dislocation of the Shoulder," Dr. Karl W. Doege, Marshfield; "Knee-Joint Injuries," Dr. Thomas J. O'Leary, Superior; "Hernia, with Especial Reference to the Internal Ring," Dr. F. Gregory Connell, Oshkosh; "Abdominal Injuries," Dr. David J. Twohig, Fond du Lac; "Atypical Abdominal Cases," Dr. Lauritz A. Larsen, Colfax; "The Management of Duodenal Fistula." Dr. Hiram C. Johnson, Bruce.

Discussors from Wisconsin of other papers included: Drs. George N. Pratt, Neenah; Fred A. Marrs, Stevens Point; David V. Meiklejohn, Fond du Lac; Ernest V. Smith, Fond du Lac; John M. Dodd, Ashland; Clarence A. Richards, Rhinelander.

DEATHS

Dr. Hubert E. Zilisch, Milwaukee, died on February 2nd following an illness of two months. Dr. Zilisch was born in Juneau, February 16, 1889, and was graduated from Marquette University School of Medicine in the year 1923. During the war Dr. Zilisch enlisted as a member of the Thirty-Fifth Division and served considerable time overseas.

The deceased was a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his wife and two small children. Pallbearers were selected from among professional associates and included: Drs. R. J. Bach, J. E. Guy, Theodore Rolfs, Millard Tufts, Ernest Miller and Alvin Kilian, all of Milwaukee.

Dr. William F. Becker, Wauwatosa, died January 29, 1927. He was born in Brooklyn, N. Y., in 1859 and graduated from the College of Physicians and Surgeons, now the Medical School of Columbia University, in 1882. He was an honor student and was awarded a prize for general excellence in scholarship. After a brief service in the neurological department of a New York hospital he came to Wisconsin in 1884 at the request of Dr. James H. McBride, then superintendent of the Milwaukee County Asylum for Insane, as assistant physician. This position he held for two years, leaving to establish a private practice in mental and nervous diseases which he continued in the city of Milwaukee for more than thirty years.

For many years Dr. Becker was consulting neurologist at the Milwaukee County Hospital. He was identified with the establishment of the psychopathic ward of the Emergency Hospital and later with the Milwaukee County clinic for mental diseases. He was also professor of mental and nervous diseases in the Wisconsin College of Physicians and in the Medical School of Marquette University.

His will testifies to his unflagging interest in the specialty to which he had devoted his life, for it provides a trust "For the advancement of mental hygiene in its broadest conceptions, namely, among other things, the prevention, treatment and cure of mental disorders, the study of their causes, and their bearing upon social mal-adjustments and upon problems of delinquency and criminology." The trustees are to give preference as to locality: first, to the city of Milwaukee; second, to communities outside the city of Milwaukee, but in the state of Wisconsin, and third, to communities outside the state of Wisconsin.

Dr. Becker was formerly a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his wife.

Dr. Frank Brockway, Oshkosh, passed away at his home on February 14th. Death was caused by a complication of erysipelas and peritonitis. Dr. Brockway was born at Chatsworth, Ill., October 26, 1869, and was a graduate of Columbus Medical College in the year 1892. He came to the city of Oshkosh twenty-eight years ago and served a number of years as county physician for Winnebago county. Dr. Brockway was also physician in charge of Sunnyview Sanatorium, and was superintendent at the state sanatorium at Wales during 1916 and 1917.

Dr. Brockway was a member of the Winnebago County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his wife and one sister.

ENGAGEMENTS

Dr. Hans H. Reese, Madison, to Miss Tessa Schmidt, of Chicago.

Dr. Robert B. Montgomery, Madison, to Miss Harriet R. Pearson, of La Valle.

MARRIAGES

Dr. John P. Koehler, health commissioner of Milwaukee, to Miss Edith A. Hulst, Milwaukee.

Dr. E. A. Brzezinski, Milwaukee, to Mrs. Mabel Morgan, also of that city.

Dr. Andrew R. Mailer, Milwaukee, to Miss Julia Hanks, Madison.

CORRESPONDENCE

BOARD OF OTOLARYNGOLOGY

St. Louis, Mo., February 7, 1927.

To the Editor:—

You will do the American Board of Otolaryngology a great favor by publishing the subjoined notice.

Yours very truly,

H. W. LOEB, Secretary.

AMERICAN BOARD OF OTOLARYNGOLOGY

The following examination dates have been assigned by the American Board of Otolaryngology:

Washington, D. C.—Episcopal Eye, Ear and Throat Hospital, Monday, May 16, 1927, at 9 o'clock.

Spokane, Washington.—Saturday, June 4, 1927, at 9 o'clock.

VOTE OF THANKS

February 4, 1927.

Mr. Geo. Crownhart,
State Medical Society,
153 Oneida St.,
Milwaukee, Wis.

Dear Mr. Crownhart:

The Academy gives you a formal vote of thanks for the books which you so kindly contributed to the Library and wishes to assure you of their appreciation.

Cordially yours,
MILWAUKEE ACADEMY OF MEDICINE.

CANCER

Baltimore, Md.

Mr. J. G. Crownhart,
The Wisconsin Medical Journal.

Dear Mr. Crownhart:

You will be very helpful to me in this endeavor on my part if you will publish this letter in your Journal and read my article in the Southern Medical Journal for January, 1927, for a possible editorial comment. I will be very glad to send you a reprint, if you will return this letter to my office.

Very sincerely yours,

JCB:EG Joseph C. Bloodgood.

Baltimore, February 3, 1927.

TISSUE DIAGNOSIS IN THE OPERATING ROOM
And Immediate Cover-Slip Examinations of all Fluids and Pus

Dear Sir:

I will consider it a courtesy if you will publish this letter in your Journal, as I am anxious to come in correspondence with pathologists and surgeons interested in the immediate examination, by frozen section, of tissue in the operating room and the immediate cover-slip studies of smears from all fluids and pus.

Microscopic examination of stained frozen sections has been possible for more than a quarter of a century. The staining of unfixed frozen sections with polychrome methylene blue and other stains is a well-established procedure. In many operating rooms in universities and other large and small surgical clinics, provisions for these immediate diagnostic studies have not only been available, but have been in practical use for years. While, unfortunately, on the other side, this diagnostic part of the operating room is conspicuous by its absence in many clinics.

Before 1915 it was rarely necessary for a surgeon well trained in gross pathology to need a frozen section to help him in diagnosis at the operating table. Since 1915, and especially since 1922, the public has become so enlightened that malignant disease formally easily recognized either clinically or in the gross, now appears in our operating rooms devoid of its easily recognized clinical and gross appearance and can only be properly discovered by an immediate frozen section. The majority of operating rooms are not equipped or prepared for this new diagnostic test.

The first essential part for this diagnosis is the technician—one to cut and stain the frozen section, or to make and stain the smear. The second is a pathologist trained to interpret it. It is possible for the surgeon to be all three in himself, and some young surgeons are so equipped. In others it is a dual combination—surgeon and pathologist in one, and the technician. More frequently it is three, operator, technician and pathologist. It makes little difference whether it is one, two or three individuals, providing each has the equipment and training for this most difficult diagnostic test.

In the address as chairman of the surgical section of the Southern Medical Association, I discussed biopsy, and this paper has been published in the Southern Medical Journal for January, 1927 (Vol. XX, page 18). A reprint of this paper will be sent to anyone on request. The chief object of this letter is to come in contact with surgeons and pathologists who are sufficiently interested in this problem to discuss it either by correspondence, or by attending a meeting in the surgical pathological laboratory of the Johns Hopkins Hospital, either the Monday before or the Friday after the meeting of the American Medical Association in Washington.

Schools for technicians may have to be established in different sections of the country, and the surgical pathological laboratories of the medical schools and the larger surgical clinics should offer courses in this tissue diagnosis, so that surgeons may learn to become their own pathologists, or pathologists learn the particular needs of the surgeon in tissue diagnosis in the operating room.

It is quite true that when the majority of the public are fully enlightened, the surgeon will see lesions of the skin and oral cavity and the majority of subcutaneous tumors when they are so small that their complete excision is not only indicated, but possible without any mutilation. The chief danger here will be a surgical mistake—the incomplete removal of an apparently innocent tumor. There is no necessity here for biopsy. If a proper local excision is done, no matter what the microscope reveals, that local operation should be sufficient. But when lesions of the skin, oral cavity and soft parts are extensive and their complete radical removal mutilating, then there must be biopsy to establish the exact pathology.

In tumors of the breast and disease of bone, for years, the diagnosis could be made clinically, or from the gross appearances at exploration. But now, an increasing number of cases, the breast tumor must be explored, and the gross pathology of this earlier stage is not sufficiently differentiated to allow a positive diagnosis. Immediate frozen sections are essential to indicate when the complete operation should be done. The same is true of the earlier stages of lesions of bone. The x-rays no longer make a positive differentiation between many of the benign and malignant diseases, for example, sclerosing osteomyelitis and sclerosing osteosarcoma.

We must not only specialize in tissue diagnosis, but we must organize this department so it will function properly in as many operating rooms as possible in this country.

Then there is a final and most difficult question to consider. I doubt if it can be settled. What shall be done in those operating rooms in which there is no technician to make the sections and no one trained to interpret the microscopic picture? How can a piece be excised or a tumor removed, for example, from the breast, and this tissue sent to some laboratory for diagnosis without incurring the risk of the delay to the patient. I have discussed this point in my paper on biopsy.

Joseph Colt Bloodgood,
Surgical Pathological Laboratory,
Johns Hopkins Hospital.

BASIC SCIENCE BOARD

THE UNIVERSITY OF WISCONSIN
Madison

Feb. 18, 1927.

The Wisconsin Medical Journal,
Milwaukee, Wisconsin.
Dear Sirs:

The Wisconsin Basic Science Board will hold its next examinations (anatomy, physiology, pathology, diagnosis) as follows:

March 19, Loraine Hotel, Madison, Wisconsin.
June 27, Hotel Pfister, Milwaukee, Wisconsin.
Examinations begin at 8:00 A. M.

Very truly yours,
M. F. Guyer,
Secretary, Basic Science Board.

REPORT OF THE COUNCIL ON PHYSICAL THERAPY

ON THE SALE OF ULTRAVIOLET GENERATORS DIRECTLY TO THE PUBLIC

The Council on Physical Therapy of the American Medical Association, on the basis of the present available evidence, is convinced that the sale of generators of ultraviolet energy to the public for self-treatment is without justification. The Council bases its condemnation of the sale of such apparatus for this purpose on the following grounds:

1. The uninformed public could not take the proper precautions in administering treatments and, as a result, severe general burns or grave injury to the eyes might ensue.

2. Those not familiar with the possibilities of such apparatus would be led to place unwarranted confidence in the therapeutic value of such treatment by the claims that might be made in the literature advertising such generators, and to undertake to treat serious conditions not amenable to such treatment.

3. The unrestricted possession of such therapeutic means would tend to deprive people of expert diagnosis by encouraging them to make self-diagnoses.

4. Such practice would encourage the sale of useless and fraudulent lamps which would be advertised as generators of ultraviolet rays, since the public would have no means at its disposal to determine the quality or quantity of the radiant energy emitted by such lamps.

For the foregoing reasons, the Council on Physical

Therapy considers as detrimental to public welfare the sale or the advertising for sale, directly to the public, of a generator of ultraviolet energy. Under rule 11 of its Official Rules, the Council will declare inadmissible for inclusion in its list of accepted devices for physical therapy apparatus manufactured by a firm whose policy is in this matter detrimental to public welfare.

Reprinted from The Journal of the American Medical Association, Jan. 22, 1927, Vol. 88, p. 245.

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SOCIETY RECORDS

NEW MEMBERS

Weisberg, Jos. H., Superior.
Haugen, Albert I., Stanley.
Hyslop, V. B., 16 No. Carroll St., Madison.
Vosburgh, W. H., Denmark.
Burke, J. J., Niagara.
Hess, John W., Adell.
Neupert, Carl N., Janesville.
Baker, Rowe G., Tomahawk.
Zeiss, A. G., Sheboygan.

CHANGES IN ADDRESS

Schiller, L., 220 W. Water St., to 123 Grand Avenue, Milwaukee.

Blumenthal, R. W., 220 W. Water St., to 123 Grand Ave., Milwaukee.

Brown, J. F., St. Louis, Mo., to Wis. State Prison, Waupun.

Hunter, H. R., 333 No. Randall Ave., Madison, to State Hospital for Insane, Mendota.

Judged by the number of bills introduced, the two popular subjects for consideration at this session of the Wisconsin legislature will be taxation and regulation of automobiles. Tax measures cover a wide range. Senator W. A. Titus, Fond du Lac, has a bill calling for the restoration of the personal property offset to the income tax. This was repealed at the last session.

There are two bills to repeal personal property taxes altogether. One by Assemblyman Wallace Ingalls, Racine, includes no method of making up the millions of dollars in revenue that would be lost through such a step. Another measure by Senator Bernard Gettelman, Milwaukee, would recover the revenue lost by the levying of a higher rate against larger incomes. The Blaine interim committee has put in a bill to exempt all motor vehicles—some 550,000 of them—from personal property taxes, the revenue to be made up by an increase in the "gas tax" from 2 to 3 cents. There are several bills to increase the gasoline tax from 2 to 2½ and as high as 5 cents a gallon. They are now pending before legislative committees, awaiting public hearings.

A bill has been presented by Assemblyman Robert B. Wood of Adams to raise the exemptions under the income tax from $800 to $1,000 for single persons, from $1,600 to $2,000 for married persons and from $300 to $400 for each dependent. In this connection, Senator V. S. Keppel, Holmen, is the author of a bill to require everyone to pay at least $5 a year income taxes if he is over 21 and is not already paying a larger sum. At the same time Senator John Schumann, Watertown, would exempt all farm animals from personal property taxes.

There are also bills to levy a 2 cent tax on cigarettes and another to impose a 10 per cent tax on milady's cosmetics. Reapportionment of the income and inheritance tax revenue also is sought in several other bills.

* * *

Aside from the automobile gas tax bills there are several others providing for indemnities in case of accidents. Assemblyman A. G. Schauer, Kewaunee, would compel every owner of an automobile, not financially able to meet accident damages, to take out liability insurance. Senator Walter Polakowski proposes to meet this situation in a different way. Under the terms of his bill every motor vehicle would be required to pay an additional fee, ranging from $5 for motorcycles, $10 for passenger automobiles; $15 for trucks to $25 for busses. These sums would go into a state indemnity fund for automobilists and out of this fund would be paid compensation for all injuries or deaths on the highways of the state. There are over thirty automobile bills introduced at this session, but most of them are of minor importance.

* * *

Two new proposals for the development of parks in Wisconsin have been introduced in the Wisconsin legislature. Senator V. S. Keppel, Holmen, has introduced a measure calling for an appropriation of $25,000 for the development of Perrot park, Trempealeau county. Senator Harry Daggett, Milwaukee, has put in a bill providing for an annual appropriation of $250,000 a year for five years for the development of state parks in southeastern Wisconsin. The expenditures of these sums would be subject to the approval of the governor.

* * *

A plan to provide beverages with 2.75 per cent alcohol in the state has been introduced in the assembly by Assemblyman Thomas Duncan, Milwaukee, and if adopted would probably lead to a court battle between the state and the federal government as to what constituted "intoxicating liquor." The Duncan bill provides that the state Severson dry law be amended to define intoxicating liquor as more than 2.75 per cent instead of the present definition of one-half of one per cent as outlined in the federal dry act. Mr. Duncan declared that his bill would make the state dry act conform with the wishes of the voters in the referendum last fall. Senator Gettelman has a bill to abolish the state prohibition commission and leave enforcement of the dry laws to the local offices.

Senator H. H. Smith, Milwaukee, has offered a bill providing that upon the fourth conviction of a person for a felony the sentence shall be to prison for life. This measure follows the provisions of the famous Baumes law of New York, which it is claimed is ridding New York city of its thugs.

* * *

Miss Harriet Grim, formerly of Darlington, has been confirmed as the woman member of the state board of control. She succeeds Mrs. Margaret Hutton Abels, Waukesha, who held the position for three years.

* * *

The poet's phrase of "over the hills to the poor house" will have to be revised if Senator Hunt's bill is approved. It has already passed the senate and is now before the assembly. He is the author of a measure to change the name of all "poor houses" in the state to "county homes." He believes there is a sting in the name "poor house" which would not attach if these institutions were called "county homes."

* * *

Early birds will be able to catch worms without the danger that their lives will be shortened by some ambitious hunter, under the terms of a bill introduced in the legislature by Assemblyman Edward F. Hilker, Racine. The Hilker bill provides that aquatic birds cannot be hunted before 7 o'clock in the morning nor after 2 o'clock in the afternoon.

* * *

Investigations promise to play a big part in the program of the present legislative session with a prospect that five probing committees will be looking into various phases of state government within a short time.

The committee to probe conditions in the state highway commission held meetings beginning February 15. The committee to investigate conditions at charitable and penal institutions has already started its work. By unanimous votes the assembly has voted to create committees, one to investigate forestry and another water power problems and the creation of these committees awaits action by the senate. A resolution is pending to investigate the much discussed subject of state inspectors.

* * *

Possibility of a short session of the Wisconsin legislature was believed removed by the deluge of bills filed before February 16th, the last opportunity of members to introduce legislation.

Present totals of approximately 500 bills in the assembly and 400 in the senate bid fair to surpass the record of the 1925 session which had 568 bills in the assembly and 576 in the senate. Committee bills may yet be introduced. Approximately 260 bills were introduced in the senate and 175 in the assembly, in one day, setting a record.

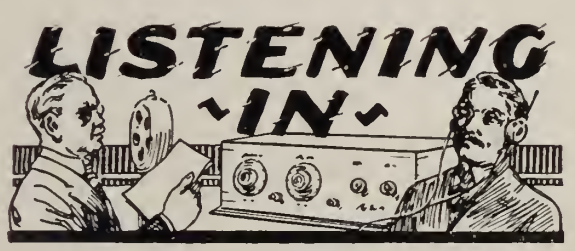
* * *

Slot machines giving packages of mints and chips, now found in all sections of the state, are gambling devices in spite of all attempts to evade the law, Attorney General John Reynolds held in an opinion to Elton J. Morrison, district attorney of Columbia county.

There is no suitable substitute for alcohol in the making of orange and lemon flavoring extracts, according to findings in tests made at the University of Wisconsin. Tests of olive, corn, peanut and cottonseed oils as substitutes for grain alcohol in lemon and orange flavoring extracts for cooking purposes have shown University of Wisconsin chemists that when used immediately the flavors in fatty oil solvents give favorable tests as to taste, but that when left standing the fatty oils become rancid and the flavors cannot be used. The tests made by Prof. H. A. Schuette and B. B. Domogalla of the department of chemistry at the state university were continued over a period of 54 months. Within 12 months the oils used as solvents had become so rancid that the flavors could not be used.

* * *

By a decision in a case from Janesville the supreme court took away any profits out of murder. A Greek resident of Janesville murdered his sweetheart and then killed himself. It was found that the girl had made a will leaving $5,000 to the man who had murdered her and his heirs attempted to claim it. The court held the will invalid in that the killing of the woman prevented her from changing it, had she desired to do so. Her property then went to her heirs and not his. The decision is based on the broad public policy that the state will not permit anyone to profit by the wrong doings of another.



NOT ETHICAL

A specialist in roentgenology moving to a new location inquires whether it would be ethical for him to send his professional card to the attorneys in the city where he is establishing his practice. He points out that roentgenology is entirely a referred practice and that much comes as result of legal cases. The Judicial Council of the American Medical Association states that it is of the opinion that such announcements would be considered as the solicitation of patients and therefore unethical.

PRACTICAL NURSES

A member inquires whether there is any rule or regulation prohibiting hospitals from employing a practical nurse. Miss Adda Eldridge, director of the State Bureau of Nursing Education, replies that in hospitals running schools of nursing, no practical or partially trained nurses may be employed except as attendants not doing any nursing work.

IN MINNESOTA

Your Secretary had the privilege of visiting the Committee on Public Policy of the Minnesota State Medical Society during February. The committee has intro-

duced in both houses a basic science measure corresponding, as near as local conditions will permit, to the Wisconsin law. Members of the committee believe that its passage is assured and are enthusiastic over the public protection benefits to be had. At the present time in Minnesota, chiropractors, osteopaths, and physicians are each licensed by separate boards and all have the same rights in treating the sick.

WHAT ARE NATUROPATHS?

This question is "answered" by a bill introduced in the Minnesota legislature to establish a state board of examiners in naturopathy. The bill states that the practice of naturopathy is defined as being "the science of healing through therapeutic agencies, being natural or drugless methods commonly employed by naturopathic physicians and shall include practice in the following branches and all, or part, of said branches as hereinafter provided, to-wit: mechanical therapeutics, hydrotherapy, physiotherapy, corrective exercises, zone therapy, chromotherapy, spondylotherapy, psychotherapy, electrotherapy, traction and vibratory therapy, suggestive therapy, magnetic therapy, diatetics, electronic therapy, iridology and all other methods of natural healing."

And thereby another important question is answered.

WISCONSIN REPRESENTED

At the annual conference on medical education and licensure held in Chicago during February, Dr. Edward Evans, La Crosse, chairman of the council, presented a paper on "The Basic Science Law in Wisconsin." This law, recently endorsed by the American Medical Association, is under consideration in many states. Dr. Evans emphasized the fact that the passage of the act was based upon the lay educational policy of the Wisconsin society.

AN INTERESTING THOUGHT

"There is no institution in the world with such a large capital that is paying so little for insurance."

This was the interesting statement of Dr. Herman Johnson of Dawson, Minn., in speaking to your secretary during February. Dr. Johnson is a past president of their state society and for the past three years chairman of the committee on public policy and legislation. He declares that the physicians of Minnesota and of Wisconsin have each between $4,000,000 and $6,000,000 invested in their profession and then pointed out that to protect this investment against ill-advised legislation and projects, they were paying but $10 in dues in Wisconsin (total $20,000) and but $15 in dues in Minnesota ($30,000).

"Can anyone doubt what the board of directors of a $4,000,000 institution would do to their executive if he reported that they paid but $20,000 or $30,000 in insurance premiums?"

OH, HOW WE FEEL

We feel for our fellow editor in whose Journal we noted that the printer set the type to read "Applesauce" instead of "Applause."

Many Bills Affecting Medical Licensure and Practice Introduced in Legislature: X-Ray Bill Would Cost Physicians Thousands

This article was written Feb. 25th. Action on bills between that date and publication date could not be included.—Editor's Note.

Ten measures directly affecting the licensure or practice of physicians were introduced in the Wisconsin Legislature by the end of February. While no measures were introduced affecting the scope of the Wisconsin Basic Science Law, bills introduced cover almost every other field of licensure and practice. Should one measure alone be adopted it would cost practically every physician in the state a $25 fee the first year and $5 a year thereafter. A brief summary of bills introduced follows.

MEDICAL SOCIETIES

88A—McDowell. This bill, introduced by request of the State Medical Society, revises and brings up to date the state law chartering the State Society and county medical societies.

AFFECTING MEDICAL PRACTICE

274A—Petersen. The present law provides that dentists may secure alcohol for the purpose of sterilizing their instruments without payment of a permit fee. This bill extends the same privilege to physicians and veterinarians.

156S—Sauthoff. This bill relating to commitment of the insane provides that the judge, without jury, may find a person insane; that a person committed and applying for release may not be so examined more frequently than once each six months, and that in commitment proceedings if a jury trial is demanded the jury shall consist of three physicians, each of whom shall be paid fifteen dollars.

AFFECTING MEDICAL LICENSURE

5A—Duncan. This bill, introduced for the Interim Committee on Taxation, would abolish special legal counsel for the state departments, including the State Board of Medical Examiners.

6A—Duncan. This bill, introduced for the Interim Committee on Taxation, provides that the State Health Officer shall be the Secretary for the following state examining boards: Medical, optometry, dental, chiropractic, basic science and pharmacy. Records of the boards would be maintained at the State Capitol.

68A—Hinckley. The present law provides that a physician convicted of a crime in the course of his professional conduct shall have his license revoked. This bill provides that the court "may" do so instead of "shall," and further, should the license be revoked, empowers the court to restore the license.

102S—White; 151A—Seftenberg. These are identical bills introduced in both Senate and Assembly. In brief this measure defines roentgenology as the use of the x-ray and "all other electrically produced rays for the diagnosis or assistance in establishment of diagnosis of pathology and the treatment of the human body."

It then provides for a special board of examiners to examine all who, now or in the future, desire to use such methods. License fee would be $25 and $5 for annual renewal. This measure would affect, with comparatively few exceptions, all physicians now in practice. Present technicians would also be licensed.

168S—Morris. This bill is introduced by request of the State Board of Medical Examiners. Its provisions are:

1. Abolishes special legal counsel.
2. Provides that foreign applicants must have first citizenship papers and have foreign credentials translated by Board. Raises license fee for foreigners from $25 to $50.
3. Present law pertaining to measures is scattered through three sections. This is compiled into one section.
4. Substitutes one examiner for masseurs instead of three.
5. Provides that the Board, rather than the Court, shall revoke licenses of those convicted of a crime in the course of their professional conduct.
6. Provides that applicants for license to practice medicine and surgery must have completed internship.
7. Provides that fee for reciprocity (now $50 in all cases) shall not be less than $50 and shall be equal to fee charged Wisconsin applicants in state from which reciprocity is desired.

239A—Withrow. This bill is introduced by request of the State Board of Medical Examiners. It provides for an appropriation of $5,000 annually to the board for the purposes of law enforcement efforts.

GENERAL HEALTH MEASURES

90S—Markham. This bill would prohibit the transportation or killing of frogs for other purposes than fishing. Should this bill be advanced, an amendment would be introduced to exempt transportation of frogs for educational and scientific purposes.

128S—Barker. This bill provides that when a county board votes on the question of employment of a county nurse, members of the board from any city, town or village which employ a local nurse, shall not vote on the question of employing a county nurse; and further, that such communities deprived of such vote shall not be taxed for the support of the county nurse.

160S—Com. on Educ. and Public Welfare. This bill would authorize the establishment of county health departments by county boards. This bill is introduced by the State Board of Health.

161S—Com. on Educ. and Public Welfare. A measure revising the law pertaining to venereal diseases. Provides also that in cases where patient refuses to take treatment, local health officer may quarantine home.

162S—Com. on Educ. and Public Welfare. At the present time the salaries of deputy state health officers are fixed by law at $3,000. This bill would remove the limitation.

163S—Com. on Educ. and Public Welfare. At the present time institutions for the care of babies are licensed by both the State Board of Control and the State Board of Health. This measure would place the licensing power entirely under the State Board of Control.

219S—Teasdale. A bill to empower the State Board of Health to adopt and enforce rules and regulations governing the purchase, sale and distribution of shoe dyes, poisonous fireworks, cosmetics, or other poisonous or noxious products other than food or drug products.

182S—Hunt. This measure provides that lye shall be labeled as poison and two antidotes listed on the label. This is a uniform state bill fostered by the American Medical Association and the State Medical Society of Wisconsin.

175A—Millar. This measure provides that the county health committee, instead of the county board, shall employ the county nurse.

—A—Duncan. A bill providing that in offenses involving moral turpitude, a city, town or village may adopt an ordinance for the physical examination of such persons.

—A—Coleman. This measure would grant the State Board of Health authority to supervise sanitary conditions in summer camps, tourist camps, etc.

State Board of Medical Examiners License Thirty by Reciprocity and Twenty-Three by Examination: Withdraw Itinerant Amendment

At a reciprocity meeting held in Eau Claire on October 5th and at the regular examination held in Madison during January, thirty were licensed by reciprocity and twenty-three by examination.

The matter of law enactment and law enforcement was discussed very thoroughly at the board meeting in Madison and it was voted to employ a full-time investigator in order to continue the program of driving quacks out of business.

The board reversed its 1926 action which declared for an amendment to the law which would prohibit itinerant practice. At the January meeting it was the consensus of opinion that such a prohibition would only envolve the board in legal entanglements and for that reason the proposed amendment was dropped from the 1927 legislative program.

Those licensed by the board are:

BY RECIPROCITY

Benjamin Franklin Cook, National Home, Wis.

Malcolm M. C. King, 1015 8th Ave., Huntington, W. Va.

Charles Olov Lindberg, Clyde, Kans.

Herald Bernard Norviel, 412 W. Illinois St., Urbana, Ill.

Edward William A. Ochsner, 1300 University Ave., Madison.
Otto Victor Pawlisch, 700 S. Ashland Blvd., Chicago.
Clarence C. Reed, 208 W. College Ave., Appleton.
Henry Otto Sommer, 247 Oneida St., Milwaukee.
Benjamin Franklin Walters, 194 W. Summit Ave., St. Paul, Minn.
Harvery Edmund Webb, Centerville, Iowa.
Thomas John Wilkin, Waupaca, Wis.
Ellis Malcomb Bond, Winneconne, Wis.
Thomas Ernest Briant, 5224 St. Antonie St., Detroit.
Adoniram B. Darling, 428 Plankinton Bldg., Milwaukee.
Horace J. Forman, Jr., 134 Second St., Milwaukee.
James W. Huffman, Statesan, Wis.
J. Leonard Lee, 1525 La Salle Ave., Minneapolis.
Wooten Dudley Lightfoot, 137 Second St., Milwaukee.
*James Waddell Lloyd, D.O., 701 E. Prospect St., Durand.
Arthur E. McMahon, Glenwood City, Wis.
Andrew R. Mailer, 711 Goldsmith Bldg., Milwaukee.
Thomas Ochsner Nuzum, 602 Milwaukee Ave., Janesville.
James Patterson, 736 Granville St., Vancouver, B. C.
Benjamin W. Provost, 633 Layton Bldg., Milwaukee.
John C. Rogers, 821 Barstow St., Waukesha.
*George Wentworth Stevens, D.O., 684 Downer Ave., Milwaukee.
Isaac Vandandaique, St. Mary's Hospital, Green Bay.
Frank F. Wagoner, Clayton, Wis.

BY EXAMINATION

*Sidney Francis Klenert, D.O., Portage, Wis.
(This man failed in the practical examination in June and he was granted the privilege of taking the examination with the reciprocity applicants.)
Jacob Joseph Baratz, 518 S. Mills St., Madison.
*H. Willard Brown, D.O., 5250 Ellis Ave., Chicago.
Ralph I. Canuteson, Wis. Gen. Hosp., Madison.
Albert C. Edwards, Southview Hosp., Milwaukee.
Harry Y. Fredrick, St. Mary's Hosp., Milwaukee.
William P. Glisch, 689 25th Ave., Milwaukee.
Douglas Nelson Gibson, Wis. Gen. Hosp., Madison.
Rodney Jones Gray, Madison Gen. Hosp., Madison.
George C. Hamilton, Winnebago, Wis.
James Samuel Hess, Jr., Mauston, Wis.
William Samuel Levy, Mt. Sinai Hosp., Milwaukee.
John M. McEachern, 927 Summit Ave., Milwaukee.
Mabel Garden Masten, Wis. Gen. Hosp., Madison.
Ovid Otto Meyer, Wis. Gen. Hosp., Madison.
Henry A. Romberg, 925 Mound St., Madison.
Anthony Frank Ruffolo, 923 Forest St., Racine.
Theodore P. Saketos, 705 Milwaukee St., Milwaukee.
Rubin H. Stiehm, Wis. Gen. Hosp., Madison.
Guy Kasten Tallmadge, 167 17th St., Milwaukee.
Milton Trautmann, Columbia Hosp., Milwaukee.
Howard McKinley Walker, 1230 Chandler St., Madison.
Franklin A. Ware, 507 64th St., Wauwatosa.
Lyman Flinn West, Wis. Gen. Hosp., Madison.

*Osteopaths.

MASSAGE

Ethel Mae Carey, 790 Booth St., Milwaukee.
Pauline Kimpel, 231 Third St., Milwaukee.
Herbert F. Ramsdell, 114 State St., Madison.
Mae J. Schafer, 3412 McLean Ave., Chicago.

Questions for the January examination follow:

CHEMISTRY

R. C. Rodecker, M.D., *Examiner*

1. Describe some chemical tests for potability of drinking water.
2. Describe briefly, but definitely, 2 tests for sugar in the urine.
3. To what is the high food value of milk due?

PATHOLOGY

R. C. Rodecker, M.D., *Examiner*

1. Give the pathology of an enlarged prostate, and explain its relation to nocturia.
2. Give pathologic sequelae of a stone in the pelvis of the kidney.
3. Describe a chronic gastric ulcer and give its possible unfavorable termination.
4. Describe the local condition of an ununited fracture.
5. Give a method of detecting albumen.
6. Describe the mode of formation and appearance of typhoid ulcer.
7. What is hemoglobin, and state some of its chief properties?
8. What is an aneurism? Name location of the most frequent.

PHYSICAL DIAGNOSIS

E. C. Murphy, D.O., *Examiner*

1. Differentiate chronic prostatitis from chronic cystitis, vesical calculus and seminal vesiculitis.
2. Name four causes of precordial pain.
3. Give the physical signs of exophthalmic goiter.
4. What is the diagnostic significance of dropsy?

Answer Three Only

NEUROLOGY

E. C. Murphy, D.O., *Examiner*

1. Define; give symptoms; etiology and diagnosis of neurasthenia.
2. Differentiate neuritis from neuralgia.
3. Give a concise discussion of anterior polic myelitis.
4. What are the general symptoms of encephalic tumors?

Answer Three Only

HYGIENE

E. C. Murphy, D.O., *Examiner*

1. Discuss the prophylaxis of the filth diseases.
2. What diseases are transmitted:
   (a) Through the respiratory system?
   (b) Through the alimentary tract?
   (c) By contact.
   (d) By inoculation?
   (e) Describe the method of transmission in each instance.

Answer Both

(Continued on Page 181.)

Wills

By C. H. CROWNHART
Justice, Supreme Court of Wisconsin
Madison

From time to time this Journal has been fortunate in having the opportunity to present to the readers articles on subjects of importance not necessarily directly related to medical practice. This exposition by Justice Crownhart falls into this type of article and will be of interest and value to every reader.—Editor's note.

The first question a man of property should ask himself is: Do I need a will[1] to pass my property upon my death in accordance with my desires?

The answer will depend upon his wishes in respect to the descent of his property. Wisconsin has laws (Chap. 237) providing for the descent of real property where there is no will. They provide that all real property shall go to the widow, if there be one, and to blood relatives. No stranger to the blood shall take any real property of a deceased person except by will. If there be no widow or blood relative, the decedent's property, in the absence of a will, escheats[2] to the state. In the case of a decedent without will, leaving a widow and no children, the widow takes all the real property. If he leaves a widow and children, the statute apportions the property between the widow and children. The statutes of descent cover a great variety of circumstances, too numerous to be considered here. But it is evident that if a person desires to leave property to charity, to a father or mother, or to children in unequal portions, or to collateral relatives, or to a stranger to the blood, he must give or devise[3] the same by will. Distribution of personal property is provided for by Chapter 318, of the statutes, where it is provided that personal property, after making certain allowances, descends the same as real property.

The statutes of descent and distribution being highly technical, it becomes important for anyone considering the distribution of his property after death to consult an attorney to ascertain if in fact he needs a will for that purpose. Most people of any considerable property need to make a will in order to distribute their property after death, both in accord with natural justice or to carry out their reasonable desires in that respect.

The Supreme Court of Wisconsin, contrary to the decisions of many other jurisdictions, has held that the right to inherit, and the right to distribute, property by will after death is a natural right preserved to our citizens by the constitution and by common law. These rights cannot be taken away without change in our organic law.

One competent to make a will must be in sound mind and free from undue influence. Generally, one competent of making a contract is competent to make a will, but wills disposing of property contrary to natural justice are valid if the testator was competent and his intent is clearly expressed. Yet courts are often critical of such wills, and they may be denied probate on rather slight proof of incompetence or undue influencee.

Where one waits to make a will until death is near and the faculties are numbed with disease, there is always the danger of contest of the will, if it be contrary to natural justice. By "natural justice" is generally meant consistent with blood relations or other bonds of natural affection. Hence, it should be plain that the making of a will is so important that one should not await approaching dissolution before attending to this solemn duty. Also, sudden and unexpected death by accident or unsuspected disease may come to anyone, and failure to have had a will properly prepared may leave unrequited someone to whom the decedent owed a duty to protect by bequest or devise.

So the admonition naturally follows: Consider the making of a will early in life, when you are in good health, and if a will is desirable, make it. Having made your will, if some change in your relations to the beneficiaries takes place, whereby the will should be changed, you should promptly have a new will executed or a codicil added to the old one.

CONSIDERATIONS FOR A WILL

Let us suppose you have decided to make a will. Before going to your lawyer to have a will drawn, it is well to give the matter some thought so that you may be able to give your lawyer explicit directions as to how you desire to dispose of your property.

Take the case of a normal situation. You have, for instance, a father or mother living, perhaps

both, a wife, and children. Natural justice suggests that the wife should have first consideration, but not necessarily so. She may have a sufficient estate of her own to meet all her requirements. But if she has not such an estate, you will naturally desire to leave her sufficient for her comfort in the station in life to which she has become accustomed. If so, a question arises: Is she of sufficient experience in business or financial matters to care for and preserve the bequest without undue hazard? If she is not, you may want to put the bequest in trust for her benefit. This will require judgment and discretion on your part. It is a well-known fact that there are schemers who watch the obituary columns and who quickly come to the aid (?) of the widow in helping her to invest her inheritance. Very often the inheritance of a widow is quickly squandered through the advice of plausible sharpers. One may wish to avoid this possibility by putting his bequest in trust for his widow and children. Here, again, is a problem that may tax your judgment. Who shall act as trustee? Your mind naturally reverts to some friend in whom you have confidence. He should be a man not only of strict integrity, but of sufficient experience to properly care for the property and investments entrusted to his care.

There are now trust companies which specialize in trusts of this character, and if the trust is to continue for long, it may be well to name a trust company as trustee. Trust companies are subject to state regulation and ordinarily should be safe. But here again you should exercise judgments they may make. For instance, I have a well provide in your will the character of investment in selecting a trust company, and you may case in mind, where a trust company, having a large estate entrusted to it, where the will gave the trustee wide discretion in the execution of the trust, invested a large proportion of the funds in the stock of a railroad company. The railroad afterwards went into bankruptcy and the trust funds so invested were largely lost. So you will need to give this matter very serious consideration. Many things will occur to you if you take time to give the matter of making your will the attention it deserves.

For instance, advances may have been made to an older son, which you may want to consider in distributing your estate; a father or mother may be left in want if you do not care for them; some charity may deserve your bounty; or, perhaps, some educational or religious association has just claims upon your generosity.

Often an attempt is made to make a gift to some favored person by giving directions in a letter or note attached to a bond or deed expressing the intent of the donor—the gift to take effect upon his death. A gift must be absolute, however, and the donor must part with the title to the property or the gift will fail. The only safe way to dispose of property, to take effect on your death, is by will.

Who may make a will? Any male or female of sound mind, of the age of twenty-one or over; or any married woman of the age of eighteen. What constitutes sound mind is a question of fact. A person of the required age is presumed to be competent to make a will, but in a contest such presumption may be overcome by evidence to the contrary.

FORMALITIES ESSENTIAL

The statutes prescribe the formalities to be observed in making a will. A person may draw his own will or he may procure another to do so. But the will must be signed in the presence of two witnesses, and these two witnesses must sign the will at the testator's request, in his presence and in the presence of each other. The witnesses need not know the contents of the will, but the testator should declare to the witnesses that the document is his will, and request their signatures thereto. No beneficiary under the will should sign as a witness, for thus he may lose his bequest.

The testator should select witnesses of good repute and of sound mind and memory, and who are likely to reside in the same place as testator or nearby so that in case of probate they may be had to testify if need be. It not infrequently happens in a contest of a will that the witnesses forget the circumstances of the signing, and sometimes they are found denying the facts. This may happen from loss of memory or from partisanship in favor of interested parties to the contest.

Lawyers frequently make the mistake of calling witnesses to a will who are handy for the purpose, failing to look to the future when the will may reach probate.

Some probate judges advise that the lawyer who gives advice to a client and drafts his will, sign the same as a witness. Frequently in a contest or in construing a will it is necessary for the court to know all the circumstances surrounding the

making of the will. The attorney who advises his client and drafts his will may be most familiar with the surrounding facts. But unless he signs as a witness he is not permitted to testify to all of the facts. Personally, I do not think attorneys should be encouraged to become witnesses in cases involving their own advice or knowledge gained from their clients. However, attorneys should keep in mind the possible contest of a will, and select witnesses of good character and reputation. Witnesses whose signatures are well known are preferable to those whose signatures are not so well known. It often happens that witnesses precede the testator in death, or they move to some foreign land, or they become incompetent. In such case the will may be proved by the presumptions that attach when their signatures are proven. While a will need be signed by only two witnesses, there is no reason why more than that number may not sign, providing they sign under the same formalities as here set forth.

When your will is made, what shall you do with it? The law provides that it may be deposited with the county judge. But this is not necessary. It may be kept by the testator or by anyone he chooses to entrust with its care. A very good way to do is to make a copy of your will to keep among your private papers, and deposit the original with the county judge. On the death of the testator, anyone in possession of a will is required to present it for probate. But the testator should have in mind that under certain circumstances the temptation is strong to destroy the will by one who is disinherited or loses by its probate.

GLOSSARY

1. The disposition of one's property, to take effect after death.
2. An accidental reverting of lands to the original lord.
3. A gift of real property by a last will and testament. In the construction of statutes the words "bequeath" and "devise" shall be held to mean the same thing.

State Society Press Service Reaches Over Million Weekly; Secretary Addresses Wisconsin Press Association

That over forty daily papers of Wisconsin and 225 weekly papers of the state are now using the press service of the State Medical Society of Wisconsin every week, was the statement of J. G. Crownhart, Secretary of the Society, in addressing the Wisconsin Press Association at Madison during February. Mr. Crownhart also announced that Mr. Dante Pierce of Des Moines, Ia., publisher of the Wisconsin Farmer, had accepted the service for regular use in that weekly. Its circulation is upwards of 110,000 in Wisconsin and is the largest farm paper of the state.

Addressing the editors of the state as "educators," Mr. Crownhart declared that he used the word advisedly.

"When you hear the word 'Educator' you think of the school teacher or of the university professor. True, they are educators teaching the young people who pass before them from year to year. But the word 'Educator' means more than those who teach children and young people. In its broader significance it means all who teach and it is with that in mind that I address you as 'educators.'

"While the school teacher tells truths and history of yesterday to tens; while the university professor teaches a few hundred, you as editors each tell and teach the truths of today to thousands and tens of thousands and sometimes to hundreds of thousands.

"You teach in your editorial columns but it is not to that which I refer. For your editorial columns may advocate much to which advocacy a considerable percentage of your readers do not agree.

"You teach when you print the news.

"And it is because you have taught prevention of disease that the baby born in Wisconsin during this hour has a life expectancy second to but one state in these United States.

"Because you have taught through your news columns that typhoid fever is a disease no one need contract, the typhoid fever death rate in Wisconsin has dropped from 24 per 100,000 in 1910 to just 1 in 1924. Some 558 died in 1910 from typhoid. Just 24 died in 1924.

"Because you have taught that tuberculosis is a preventable disease, the death rate in Wisconsin has dropped from nearly 110 per 100,000 in 1909 to 62.3 in 1925.

"Because you have taught that tuberculosis should not be 'Captain of the Company of Death,' 20,000 people are living in Wisconsin today who would have died of this disease had the death rate of 1909 continued.

"Because you taught the mothers of Wisconsin that babies were born to live, not to die, the death rate of babies under one year of age in Wisconsin has dropped from 119.7 per 1,000 in 1909 to 69.9 in 1923 and further reductions are being made.

"Because you taught the people of Wisconsin that there were scientific means of preventing contagious disease epidemics, the death rate of scarlet fever has dropped from 15 per 100,000 in 1909 to 3.7 in 1925 and the death rate of measles has dropped from 11.8 per 100,000 in 1916 to 2.2 in 1925.

"What educator can point to a more glorious record of service to his fellowmen?

"You may say 'But is this not the record of medical science?'

"And I will answer—the greatest discoveries of medical science in the prevention of disease and the prolongation of life are useless unless a whole people knowing of them shall make use of them. It is you as educators who, through your daily columns, have brought to your fellowmen and women the realization that no one need have smallpox; that a case of typhoid fever is a disgrace to someone; that diphtheria can be prevented and tuberculosis can be cured. And just as the people of Wisconsin have learned the lessons you have taught, so have they added years to their lives until today fifteen years have been added to the average life as compared to just half a century ago.

"You have taught the people of Wisconsin that no news you print is so important to each one personally, day after day, as the steady forward march of medical science in the prevention and cure of disease. They may read the arithmetic of the stock market; the history of current events, the geography of treaties and the English of statesmen but you know and I know that through repetition they memorize and apply the lessons you teach in health.

"Is it not universally true that we are never really happy in our day by day work unless we feel that we are contributing something useful, something helpful to our fellowmen? Certainly this is true in the medical profession and physicians have long realized the truth of the statement: 'Unless you are the keeper of your brother's health you may soon become the possessor of your brother's disease.'

"But it was not until the profession turned to the press for assistance that we have seen the great strides forward in the field of disease prevention. Realizing how much had been accomplished through but a haphazard service to the press, the physicians of Wisconsin a little over a year ago offered to the press of this state, without charge, an article a week on some phase of disease preventive efforts. Throughout the state physicians have been called upon to contribute to this service and every effort has been made that each article shall speak only of those means the value of which has been weighed and proven. In the year that this service has been rendered the number of editors availing themselves of the offer has grown from but a handful to over two hundred and sixty.

"The service has been placed under the direction of an experienced newspaper man that each article might best present the news it contained. From the clippings that pour over the desk of the speaker we learn that this service is being used beyond all expectation. And each week's story brings letters from your readers asking for more details. When your readers take the time to write for more you may be sure you are presenting them with the news they want.

"So we have in Wisconsin today the physicians as a group on the one hand, furnishing the press with the scientific information they possess interpreted into a language the non-medical public may read, understand and apply; and on the other hand, the press of the state printing this information each week reaching hundreds of thousands of readers, and both groups working to render a mutual service in the interest of making Wisconsin the healthiest state in the Union and giving to its people longer and happier lives.

"Next week the President of the State Medical Society is addressing a personal letter to you offering information on the subject of suicide waves and suggesting means by which, with your aid, they may be brought to an end. Again, I venture to say, the press and medical profession will cooperate for no selfish end but the public good. Both know that there is a profit realized from true service that exceeds any temporary profit of selfishness.

"I cannot close here without paying tribute to two Wisconsin editors who were educators in every sense of the word. Both were editors of the Southport (now Kenosha) Telegraph. I refer to

Educator Michael Frank who in 1843 saw crowned with success his efforts to secure for Wisconsin a free school system. And I refer to Educator C. Latham Sholes who in 1873 invented the typewriter without which the great educational and business movements of this country could not be carried to success.

"Let us here pay tribute to these editors who attained not a material success but a living success, because they were editor-educators. The editors of today render a comparable service when they educate their people to the fact that we may add ten years to our span of life and increase our happiness and productiveness by only using care and those scientific means for disease prevention which are now known. Your aid in this great teaching effort but emphasizes my salutation to you which is now my closing remark—'Editors and Educators.'"

DAILY PAPERS USE SERVICE

Ashland Daily Press.....Ashland
Antigo Daily Journal.....Antigo
Appleton Post-Crescent.....Appleton
Daily News.....Beloit
Journal.....Berlin
Baraboo Daily Republic.....Baraboo
Telegram.....Chippewa Falls
Leader.....Eau Claire
Daily Telegram.....Eau Claire
Reporter.....Fond du Lac
Press-Gazette.....Green Bay
Gazette.....Janesville
Kenosha Evening News.....Kenosha
Sentinel.....Milwaukee
Kuryer Polski.....Milwaukee
Times.....Manitowoc
Herald-News.....Manitowoc
Eagle-Star.....Marinette
Leader.....Milwaukee
Wisconsin News.....Milwaukee
Journal.....Milwaukee
Capital Times.....Madison
State Journal.....Madison
Nowiny Polskie.....Milwaukee
Herald.....Merrill
Daily News-Times.....Neenah
Daily Northwestern.....Oshkosh
Register-Democrat.....Portage
Times-Call.....Racine
Journal-News.....Racine
Telegram.....Superior
Courier Hub.....Stoughton
Rolnik.....Stevens Point
Press.....Sheboygan
Daily Journal.....Stevens Point
Amerika.....Sheboygan
Tribune.....Wisconsin Rapids
Daily Freeman.....Waukesha
Register.....Whitewater
Daily Record-Herald.....Wausau
Daily Times.....Watertown

MISCELLANEOUS

J. M. Klaner.....Cassville
Dr. Olin West.....535 N. Dearborn St., Chicago
Dr. John M. Dodson.....535 N. Dearborn St., Chicago
Dr. Frank L. Rector.....22 E. Ontario St., Chicago
T. A. Hendricks.1004 Hume Mansur Bldg., Indianapolis
Dr. A. M. Carr.....Madison
J. G. Crownhart.....153 E. Wells St., Milwaukee
Dr. H. E. Dearholt.....558 Jefferson St., Milwaukee
Maude Stearns.....370 7th Ave., New York
Sen. W. A. Titus.....Fond du Lac
Kings Co. Medical Society.....Brooklyn, N. Y.

MAGAZINES

Wisconsin Farmer.....Madison

WEEKLY PAPERS

Athens Printing Co.....Athens
Leader.....Arcadia
Union.....Augusta
Free Press.....Amery
Amherst Advance.....Amherst
Brandon Times.....Brandon
Bayfield Co. Press.....Bayfield
Brillion News.....Brillion
Boscobel Dial.....Boscobel
Brodhead News.....Brodhead
Record.....Bloomington
Bruce News Letter.....Bruce
Dane Co. News.....Black Earth
Bloomer Advance.....Bloomer
Blair Press.....Blair
Farm News.....Black River Falls
Brooklyn Teller.....Brooklyn
Bulletin.....Baldwin
News.....Baraboo
Independent-Register.....Brodhead
Barron Co. Tribune.....Barron
Blade.....Blanchardville
Bayfield Progress.....Bayfield
Barron Co. News-Shield.....Barron
Polk Co. Ledger.....Balsam Lake
Belleville Recorder.....Belleville
Argus.....Beaver Dam
News-Herald.....Cuba City
Phonograph.....Colby
Chetek Alert.....Chetek
Cornell Courier.....Cornell
News.....Campbellsport
Advance.....Cumberland
Messenger.....Colfax
Columbia Republican.....Columbus
Times-Observer.....Clinton
Advance.....Clayton
Enterprise.....Cudahy
News.....Cambridge
Recorder.....Cochrane
Forest Republican.....Crandon
News.....Cedarburg
Times.....Chilton
Sentinel.....Cadott

Reporter ..... Cazenovia
Dairyman Gazette ..... Clintonville
Courier-Wedge ..... Durand
Bi-County Argus ..... De Soto
Delavan Republican ..... Delavan
Deerfield News ..... Deerfield
Journal-Democrat ..... DePere
Weekly Clarion ..... Dorchester
Press ..... Denmark
Weekly Index ..... Dousman
Enterprise ..... Downing
Enterprise ..... Delavan
News ..... East Troy
Review ..... Evansville
Pierce Co. Herald ..... Ellsworth
Vilas Co. News ..... Eagle River
Review ..... Eagle River
Frederic Star ..... Frederic
Jefferson Co. Union ..... Ft. Atkinson
Fennimore Times ..... Fennimore
Buffalo Co. Republican ..... Fountain City
Democrat ..... Ft. Atkinson
Times ..... Gillett
Enterprise ..... Glidden
Broadcaster ..... Genoa City
Herald ..... Granton
Reporter ..... Green Lake
Hancock News ..... Hancock
Reporter ..... Horicon
Sentry Enterprise ..... Hillsboro
Enterprise ..... Humbird
Willie Kaul ..... Hustisford
News ..... Hammond
Press ..... Hartford
Press ..... Highland
Montreal River Miner ..... Hurley
News ..... Hurley
News Wave ..... Independence
Herald ..... Iola
Independent ..... Juneau
Banner ..... Jefferson
Community News ..... Juda
Events ..... Kilbourn
Tri-County Herald ..... Kiel
Kewaunee Co. Press ..... Kewaunee
Keystone ..... Kendall
Review ..... Lomira
Herald ..... Lancaster
Loyal Tribune ..... Loyal
Enterprise ..... Luck
Enterprise ..... La Farge
America Herald ..... La Crosse
News-Tribune ..... Lake Geneva
Herald ..... Markesan
Times ..... Monroe
Journal Telephone ..... Milton Junction
Herald ..... Milwaukee
News ..... Marshfield
Times ..... Mosinee
Chronicle ..... Melrose
Times ..... Minocqua
Catholic Citizen ..... Milwaukee
Star-Advocate ..... Merrill
Dunn Co. News ..... Menomonie
Advertiser ..... Marion
Herald-News ..... Mondovi
Mt. Horeb Mail ..... Mt. Horeb
Der Landmann ..... Milwaukee
Mukwonago Chief ..... Mukwonago
Mt. Horeb Times ..... Mt. Horeb
Jewish Press ..... Milwaukee
Green Co. Herald ..... Monroe
Vestnich ..... Milwaukee
Tribune ..... Mineral Point
Juneau Co. Chronicle ..... Mauston
Mayville News ..... Mayville
Iowa Co. Democrat ..... Mineral Point
Czechoslovak ..... Milwaukee
America Herold ..... Manitowoc
Mellen Weekly Record ..... Mellen
Neillsville Press ..... Neillsville
Reporter ..... New Holstein
Times-Argus ..... New London
News ..... New Richmond
Necedah Republican ..... Necedah
Press ..... New London
Post ..... New Glarus
Republican ..... New London
Osceola Sun ..... Osceola
Enterprise ..... Oconomowoc
Oconto Co. Reporter ..... Oconto
Herald ..... Oconto Falls
La Crosse Co. Record ..... Onalaska
Normal Advance ..... Oshkosh
Journal Printing Co. ..... Oxfordville
Observer ..... Oregon
Ojibwa Courier ..... Ojibwa
News ..... Osseo
Enterprise ..... Owen
Phillips Times ..... Phillips
Homecroft Printers ..... Polley
Enterprise ..... Palmyra
Press ..... Poynette
The Bee ..... Phillips
Record ..... Pittsville
Grant Co. News ..... Platteville
Independent ..... Park Falls
Herald ..... Pepin
Record ..... Pittsville
Crawford Co. Press ..... Prairie du Chien
Witness ..... Platteville
Review ..... Plymouth
Ripon Press ..... Ripon
Times ..... Reedsburg
Review ..... Rosholt
Republican Observer ..... Richland Center
Advance ..... Randolph
Free Press ..... Reedsburg
Journal ..... River Falls
Chronotype ..... Rice Lake
Herald ..... Rib Lake
Times ..... River Falls
Rio Journal ..... Rio
Commonwealth ..... Ripon

Wisconsin Agriculturist ..... Racine
Washburn Co. Register ..... Shell Lake
Standard Press ..... St. Croix Falls
Shawano Co. Leader ..... Shawano
Countryman ..... Sun Prairie
Republican ..... Stanley
The Sun ..... Spring Valley
Sheboygan Co. News ..... Sheboygan
Sharon Reporter ..... Sharon
Kickapoo Scout ..... Soldiers Grove
Journal ..... Stratford
Pionier Presse ..... Sauk City
Typomie ..... Superior
Journal ..... Shawano
Spooner Advocate ..... Spooner
Seymour Press ..... Seymour
Advocate ..... Shawano
Superior Labor Journal ..... Superior
Volksbote-Wochenblatt ..... Shawano
Door Co. News ..... Sturgeon Bay
Sparta Herald ..... Sparta
Monroe Co. Democrat ..... Sparta
Weekly Home News ..... Spring Green
Tomah Journal ..... Tomah
Weekly Herald ..... Taylor
Chronicle ..... Tigerton
Thorpe Center ..... Thorpe
Leader ..... Tomahawk
Reporter ..... Two Rivers
Herald ..... Tomah
Vernon Co. Censor ..... Viroqua
News ..... Viola
Wauzeka Chief ..... Wauzeka
Chronicle ..... Weyauwega
Times ..... Westby
News ..... West Allis
Times ..... Walworth
Enterprise ..... Wittenberg
Nonpareil Journal ..... West Salem
Waushara Argus ..... Wautoma
Waupaca Co. Post ..... Waupaca
Waterford Post ..... Waterford
Clintonville Tribune ..... Wittenberg
Leader & News ..... Waupun
Tribune ..... Waunakee
Courier ..... Waterloo
News ..... West Bend
Advertiser ..... Wabeno
Independent ..... Wausaukee
Times ..... Washburn
Times ..... Whitehall
Times ..... Woodville

STATE BOARD EXAMINATION

(Continued from Page 174.)

PRINCIPLES AND PRACTICE OF MEDICINE

J. Gurney Taylor, M.D., *Examiner*

Answer the first five (5) questions, any two (2) questions may be selected from the remaining. Seven (7) must be answered.

1. Give symptoms of abscess of liver, differentiating from empyema of gall-bladder and gall-stones.
2. Palpitation of heart: state symptoms, diagnosis, etiology and treatment.
3. Describe a moderately severe case of exophthalmic goiter; give one diagnostic test in detail.
4. State physical signs of vesicular emphysema of lungs, symptoms and treatment.
5. Define herpes zoster, giving symptoms and treatment.
6. Give causes of epistaxis.
7. Name four (4) types of malaria, giving symptoms of acute forms.
8. Give symptoms and treatment of hydronephrosis.
9. Give physical signs, differential diagnosis and treatment of acute diaphragmatic pleurisy.
10. Give etiology of toxic hemoglobinuria.

PEDIATRICS

J. Gurney Taylor, M.D., *Examiner*

1. What are the most frequent complications of scarlet fever?
2. Outline treatment of enuresis in a child of six (6) years, also give etiology and symptoms.
3. Give symptoms of simple stomatitis, and treatment.
4. Differentiate varicella from impetigo contagiosa.
5. Give differential diagnosis, in an infant of one year, of left pleural effusion and lobar pneumonia involving left lower lobe and prognosis and treatment.

MATERIA MEDICA

T. J. Sheehy, M.D., *Examiner*

1. How do styptics and hemostatics differ? Give an example of each.
2. Name two important intestinal antiseptics, the diseases in which they are indicated and explain how they are used.
3. Name three mineral acids and mention the special properties of each.
4. (a) Name the official bromides.
   (b) What is the alkaloid of pomegranate and for what is it used?
5. What is cumulative action? Name one drug that has this tendency, and give the symptoms of such action.
6. (a) What are the therapeutic uses of sulphur? Of potassium chlorate?
   (b) Mention three conditions in which serum therapy has proved successful.
7. Write a complete prescription for a child of four years suffering with pertussis (whooping cough).
8. In what strength would you use solutions of silver nitrate, boric acid and permanganate of potash for injection into the bladder?

TOXICOLOGY

T. J. Sheehy, M.D., *Examiner*

1. How should a case of poisoning with chloral hydrate be treated?
2. What are the earliest signs of poisoning from the external use of carbolic acid?
3. Treat a case of carbon monoxide gas poisoning.

(Continued on Page 186.)

THE JOURNAL BOOK SHELF

Life Insurance Medicine. A study of some of its problems and their relation to clinical medicine by members of the medical department of the New England Mutual Life Insurance Company. Volume I, published by New England Mutual Life Insurance Co., Boston. 1926.

Young's Practice of Urology. Based on a study of 12,500 cases. By Hugh H. Young, M.D., and David M. Davis, M.D., Johns Hopkins University, with the collaboration of Franklin P. Johnson. Two octavo volumes totaling 1,484 pages with 1,003 illustrations, 20 being color plates. Per set: Cloth, $25.00 net. W. B. Saunders Company, Philadelphia and London.

The Human Cerebrospinal Fluid. An investigation of the most recent advances, as reported by the Association for Research in Nervous and Mental Disease. The proceedings of the association; New York, December 29th and 30th, 1924. With 77 illustrations and 58 tables. Paul B. Hoeber, New York, 1926.

Report on Third International Congress of Military Medicine and Pharmacy. Paris, April, 1925. By Commander William Seaman Bainbridge, M.C., United States Naval Reserve Forces, Member of Permanent Committee, Delegate from the United States. Reprinted from The Military Surgeon, May to August, 1926, inclusive, Washington, D. C.

The Normal Child and How to Keep It Normal in Mind and Morals. Suggestions for parents, teachers and physicians; with a consideration of the influence of psychoanalysis. By B. Sachs, M.D., New York. Price $1.50 net. Paul B. Hoeber, Inc., Medical Publishers, New York City.

Diseases of Women. By Harry Sturgeon Crossen, M.D., Prof. of Clinical Gynecology, Washington University Medical School and Gynecologist in Chief to the Barnes Hospital and the Washington University Dispensary; Gynecologist to St. Luke's Hospital. Sixth edition, revised and enlarged, with 934 engravings, including one color plate. Price $11.00. C. V. Mosby Company, St. Louis, 1926.

Surgical Clinics of North America. Vol. VI, No. 4, Mayo Clinic Number, October, 1926. Pages, 274 with 91 illustrations. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

Medical Clinics of North America. Vol. X, No. 3, Mayo Clinic Number, November, 1926. Octavo of 275 pages with 55 illustrations. Per Clinic year, July, 1926, to May, 1927. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

Shell Shock and Its Aftermath. By Norman Fenton, Ph.D., Associate Prof. of Psychology, Ohio University. Illustrated. Price $3.00. C. V. Mosby Company, St. Louis, 1926.

Practical Surgery of the Joseph Price Hospital. By James William Kennedy, M.D., Surgeon to the Joseph Price Hospital, Philadelphia; Consulting surgeon to the Norristown, Coatesville and Chambersburg Hospitals; formerly in charge of the Gynecological and Obstetrical Department of the Philadelphia Dispensary. Illustrated with 129 original half tone plates, some in colors. Price $10.00 net. F. A. Davis Company, Philadelphia, 1926.

Transfusion of Blood. By Henry M. Feinblatt, M.D., Asst. Clinical Professor of Medicine, The Long Island College Hospital, Brooklyn, N. Y. Illustrated by 24 engravings. The Macmillan Company, New York, 1926.

Nasal Accessary Sinuses. Pathology and treatment of the inflammatory diseases of the nasal accessory sinuses. By Prof. Dr. M. Hajek, Chief of the Laryngo-Otological Clinic, University of Vienna. Translated and edited by Joseph D. Heitger, M.D., Louisville, Ky., and French K. Hansel, M.D., St. Louis, Mo. Price $17.00. Fifth edition, completely revised and enlarged. C. V. Mosby Company, St. Louis, 1926.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared original articles by leading members of the medical profession throughout the world. Volume IV, thirty-sixth series, 1926. J. B. Lippincott Company, Philadelphia and London, 1926.

Readings in Abnormal Psychology and Mental Hygiene. Edited by W. S. Taylor, Prof. of Psychology in Smith College, with an introduction by Joseph Jastrow, Prof. of Psychology in the University of Wisconsin. D. Appleton and Company, New York and London, 1926.

Physiology and Biochemistry in Modern Medicine. By J. J. R. Macleod, M.B., Prof. of Physiology in the University of Toronto, Toronto, Canada; assisted by Roy G. Pearce, A. C. Redfield, N. B. Taylor and J. M. D. Olmsted. Fifth edition, with 291 illustrations, including 9 plates in colors. Price $11.00. C. V. Mosby Company, St. Louis, 1926.

The Practice of Medicine. By A. A. Stevens, M.D., Prof. of Applied Therapeutics in the University of Pennsylvania. Second edition, entirely reset. Octavo of 1174 pages. Cloth, $7.50 net. W. B. Saunders Company, Philadelphia and London.

BOOKS RECEIVED FOR REVIEW

Symptom Diagnosis, Regional and General. By Wilfred M. Barton, M.D., Associate Professor of Medicine, Georgetown University, and Wallace M. Yater, M.D., Fellow in Medicine, Mayo Foundation, Rochester. D. Appleton & Company, New York and London, 1927.

A Manual in Preliminary Dietetics. By Maude A. Perry, B.Sc., Director of Dietetics, the Montreal General Hospital, Montreal. Price $1.25. C. V. Mosby Company, St. Louis, 1926.

Hospital Housekeeping and Sanitation. By Nora P. Hurst, R.N. Price $1.25. C. V. Mosby Company, St. Louis, 1926.

Surgical Clinics of North America. New Jersey number, December, 1926. Pages, 318, 93 illustrations and complete index to Vol VI. Per clinic year, February, 1926, to December, 1926: Paper, $12.00; cloth, $16.00, net. W. B. Saunders Company, Philadelphia and London.

Medical Clinics of North America. Vol. X, No. 4, New York Number. W. B. Saunders Company, Philadelphia and London, 1927.

Old Friends Are Best

TIME provides the acid test for many things. Acquaintance grows into respect and respect into friendship as the years pass and positive qualities have an opportunity to assert themselves. It is thus with human friendships, and we see a marked parallel in the relation of the physician to the drugs upon which he relies.

New and untried remedies come and go. Many enjoy a brief moment of popularity. Few survive the acid test of time.

Creosote is still a favorite drug for use in the treatment of bronchitis, tuberculosis, and as an intestinal and urinary antiseptic. Its expectorant and antiseptic properties are generally recognized and the discovery of Calcreose more than a score of years ago has largely overcome its principal defect, which was the tendency to cause gastric disturbance.

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Another advantage of Calcreose over plain creosote is that it is a powder and can be manufactured into tablets, thus facilitating the administration of this valuable drug.

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What They Cost You?

When to Clip Your Coupons?

When Dividends are Due?

How Your Income is Distributed?

What Your Profits and Losses Have Been for Your Tax Record?

These are only a few items of information, to which one of our Stock and Bond Registers gives easy access. For the forehanded investor, it is not only a simple method for recording all data about holdings; it is a necessity.

Send for our Stock and Bond Register if your holdings are less than $20,000. Our Loose Leaf Record is what you want if your investments are more.

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A Primer for Diabetic Patients. By Russell M. Wilder, M.D., Section on Nutrition, Division of Medicine, Mayo Clinic. A brief outline of the treatment of diabetes with diet and insulin, including directions and charts for the use of physicians in planning diet prescriptions. Third edition, reset, 134 pages. Price, $1.50, net. W. B. Saunders Company, Philadelphia and London, 1927.

South America. A guide book for lay and professional travelers. By Franklin H. Martin, M.D., in collaboration with William J. Mayo, M.D., Francis P. Corrigan, M.D., and Edward I. Salisbury, M.D. Price, $3.00. Fleming H. Revell Co., 158 Fifth Ave., New York City.

Four Thousand Years of Pharmacy. An outline history of pharmacy and the allied sciences. By Charles H. LaWall, Ph.M., Prof. of Theory and Practice of Pharmacy and Dean of the Philadelphia College of Pharmacy and Science. Illustrated. J. B. Lippincott Co., Philadelphia and London.

Exodontia. A textbook of Exodontia, Oral Surgery and Anesthesia. By Leo Winter, D.D.S., Prof. of Oral Surgery, New York University College of Dentistry. With 329 illustrations. Price, $7.50. C. V. Mosby Company, St. Louis, 1927.

Dental Materia Medica and Therapeutics. With Special Reference to the Rational Application of Remedial Measures to Dental Diseases. A textbook for students and practitioners. By Herman Prinz, D.D.S., M.D., Prof. of Materia Medica and Therapeutics, The Thomas W. Evans Museum and Dental Institute School of Dentistry, University of Pennsylvania. Sixth edition, enlarged and revised according to the United States pharmacopeia, tenth decennial revision. Price, $6.00. C. V. Mosby Company, St. Louis, 1926.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 153 Oneida Street, Milwaukee, Wisconsin. These new books will be loaned for an inspection period only.

Principles and Practice of Chemotherapy with special reference to the specific and general treatment of syphilis. By John A. Kolmer, M.D., Prof. of Pathology and Bacteriology in the Graduate School of Medicine, University of Pennsylvania. Pages, 1106 with 82 illustrations; price, cloth, $12.00, net. W. B. Saunders Company, Philadelphia and London.

This book is an extremely comprehensive book on the medicinal treatment of syphilis and allied diseases. It is a large volume of over a thousand pages and every aspect of anti-syphilitic treatment of syphilis in all its forms is most carefully presented. There is hardly a question concerning the chemotherapy of syphilis which is not answered. Altogether it is the most detailed and all embracing book on this subject which has ever come to the attention of the reviewer. It can be most enthusiastically recommended to any physician who treats any type of syphilis or allied condition.—B. B. R.

A Manual of Pharmacology and Its Application to Therapeutics and Toxicology. By Torald Sollmann, M.D., Professor of Pharmacology and Materia Medica in the School of Medicine of Western Reserve University, Cleveland. Third edition, entirely reset. W. B. Saunders Company, Philadelphia and London.

This third edition of Sollman's splendid work on Pharmacology and Its Application to Therapeutics and Toxicology is most welcome. It is a great improvement on the previous work in that it has been brought thoroughly up-to-date; the discussions are clear and concise, and the book is one of the very best dealing with the subject matter. It is a prodigious effort to produce such a work which is at once a textbook as well as a book of reference. The book cannot be recommended too highly to all those who are interested in the pharmacological action of drugs as well as in their practical uses.

The subject matter is divided into large type material, in which the most essential facts are presented, and smaller type to be read by those who are particularly interested in the details. This is a very great convenience. A very extensive bibliography is presented in Appendix C, which will be of great use to those who desire to go into the original literature.

—A. S. L.

Report of the Department of Health of the City of Chicago for the Years 1923, 1924, and 1925. By Herman N. Bundesen, M.D., Commissioner of Health, Chicago, 1926.

This triennial report of the Chicago Department of Health is a very complete reference for all the various activities which are included in the modern Department of Health of a large city. There are numerous tables with comparisons of everything pertaining to health in previous years with recent years. Such a report illustrates the enormous amount of work which is being done throughout the United States to conserve the Nation's Health.—L. M. W.

South America. A guide book for lay and professional travelers. By Franklin H. Martin, M.D., in collaboration with William J. Mayo, M.D., Francis P. Corrigan, M.D., and Edward I. Salisbury, M.D. Price, $3.00. Fleming H. Revell Co., 158 Fifth Ave., New York City.

The frontispiece is of the president of the United States, Calvin Coolidge; there is an introduction by Dr. William J. Mayo, and the detailed itineraries which were followed by the contributors to the volume.

First edition, published in 1923, has been completely revised, and amplified to include all of the Latin American countries. Section I of the book contains a chapter on each of the Latin American countries, with a full and complete description and many illustrations.

Section II contains a summary report of the relation of the American College of Surgeons to the Latin American countries.

Section III deals extensively with the surgeons and

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the medical institutions of Latin America, and is profusely illustrated. Any medical man who contemplates a trip to any of the Latin American countries will find "South America" invaluable.

Section IV contains a complete summary of facts, historical, geographical, political, social and industrial. In this portion of the book may be found a summary of all information that may be of interest either to the traveler or to the historian.

Section V contains an English-Spanish and English-Portuguese vocabulary which would be most helpful and almost invaluable to anyone contemplating a voyage to Latin America, and both vocabularies are a splendid basis for the study of Spanish or Portuguese.

Section VI contains tables of weights and measures, both the standard and metric systems, and a comparison of the two.

Section VII is a complete index of "South America."

An Introduction to the Practice of Preventive Medicine. By J. G. Fitzgerald, M.D., Prof. of Hygiene and Preventive Medicine and Director, School of Hygiene and Connaught Laboratories, University of Toronto; assisted by Peter Gillespie, Prof. of Civil Engineering, University of Toronto and H. M. Lancaster, Chief Dominion Analyst, Department of Health, Canada. Second edition; price, $7.50. C. V. Mosby Company, St. Louis, 1926.

This book is written primarily for the general practitioner in the smaller communities who wishes to take advantage of the exceptional opportunities offered in the practice of preventive medicine. The book covers all of the infectious and communicable diseases with exceptionally good chapters devoted to the problems of prevention and methods of control. There are special chapters on water, food and milk, with special reference to inspection and care in urban and rural communities. Another chapter deals with "The Public Health Organizations," and an explanation of the Canadian system. The book would make an excellent textbook for the undergraduate in medicine, presenting to him the advantages of preventive medicine, and as such ought to have a place in all medical schools.

—P. A. T.

History Taking and Recording. By James A. Corscaden, M.D., Associate in Obstetrics and Gynecology, Columbia University, New York. Price, $1.50. Paul B. Hoeber, Inc., New York, 1926.

The art of diagnosis is very largely based upon the skill of history taking, and much chagrin could be spared the physician were he at all times sufficiently alive to this prime essential. History taking may well be classed in importance with the basic sciences—so fundamental is its value.

This volume has much to commend it. The author dwells briefly, but in a clear cut and concise manner, upon the phases of history taking and the pitfalls of insufficient evidence; he urges, among other things, that there is a technique of history taking, and that, for example, given such handicaps as the patient's not speaking English, or being unintelligent or uncooperative, "a student can master the difficulties of intelligence, language and personality, if he but accept this principle and assume the objective attitude while taking his history, obtaining his information from whom and by whatsoever method he will, utilizing it as it seems best to him, and presenting the history as his own interpretation." Emphasis is placed upon the use of tact, adaptability, intuition and sympathy, in order to draw out the desired information—certainly these are qualities essential to results.

In a second division the author puts in a practical manner the essentials of a history, in order to present it as a systematic and comprehensive analysis.

In a final chapter are listed terms usually employed in history taking, covering in detail every possible descriptive designation of symptoms—thus simplifying for the student, interne, or physician, his efforts at accurately stating his case.

All in all, this little volume is a painstaking effort to emphasize to the profession the importance of a branch of diagnostic essential that is generally given a scant hearing, but one that rightly reserves a higher place.

Dr. Corscaden's book is heartily commended for general adoption.—A. J. P.

STATE BOARD EXAMINATION

(Continued from Page 181.)

SURGERY

ROBT. E. FLYNN, M.D., *Examiner*

Answer any 8 questions.

1. a. Define fracture of bone.
   b. Classify fracture.
   c. Name 5 complications of fractures that may cause death, prolonged convalescence, or poor health.
2. Describe clinical finding and give your method of treating one of the following—
   a. Colles fracture.
   b. Potts fracture.
   c. Fracture lower third of femur.
3. a. Name four acute abdominal diseases treated best surgically.
   b. Describe one of these as to—
      1. Symptoms.
      2. Physical signs.
      3. Laboratory findings.
      4. Briefly outline treatment.
4. a. Define surgical shock.
   b. Treatment.
5. Discuss empyema—pleural.
   a. Etiology.
   b. Treatment.
6. a. Define—osteomyelitis acute.
   b. Symptoms.
      1. Subjective.
      2. Objective.
7. What symptoms would cause you to suspect renal tuberculosis? How diagnose? How treat?
8. Name four congenital abnormalities. Discuss briefly one of these.
9. Name four common types of ulcer of leg below knee

The Wisconsin Medical Journal

Volume XXVI | Milwaukee, April, 1927 | Number 4

Some Observations on the Etiology, Diagnosis and Treatment of Massive Collapse of the Lung and Allied Conditions*

BY JOSEPH BRENNEMANN, M.D.
Chicago

The term "massive collapse of the lung" was introduced in the medical literature by an English physician, Pasteur (not Louis), about twenty-eight years ago. In 1908 Pasteur wrote a paper which embodied the result of his observations on post mortems in children who had died after diphtheria. In those post mortems he had found in many cases areas of atelectasis, areas of deflation of the lung, areas in which the air had been completely absorbed from the lung and the lung had been contracted. He applied to this the term "massive collapse" and offered the explanation that it was due to a paralysis of the diaphragm on the side on which the collapse took place. Whether that explanation was right or not I will discuss a little later; it is rather questionable. Such areas of collapse may be very small as he found them, or they may involve the whole lung.

Since Pasteur's original observations were published and since the name "massive collapse" was put into the literature, there has been a very extensive literature on this subject. Chevalier Jackson and Walter Estell Lee of Philadelphia recently cited some seventy-five papers on this subject, and yet there does not seem to be very much information current with reference to the matter.

After the first observations that Pasteur made, he observed further in 1910 that similar conditions of massive collapse of the lung, perhaps we ought to call it atelectasis but the other word is in use, occurred after abdominal operations, and in 1914 he once more wrote on this subject and reported that out of 201 post-operative pulmonary complications eight per cent of them were not a pneumonia or an embolus or anything of that sort, but a pulmonary collapse, that is, a condition in which the lung had contracted secondary to an operation.

There is practical unanimity as to what the pathology or rather the anatomy of the situation is. There is apparently a condition produced as the result of which the air is withdrawn from the alveoli, the bronchi are not contracted, but the lung, if over a large area, say a whole lobe or a half lobe, shrinks because of the absorption of air from it, and as a result if there is considerable involvement the other organs adjacent to the thoracic cavity are drawn over into that region. Perhaps in those cases the word "massive collapse," because the word "collapse" suggests "sudden," may be all right, because quite often these are rather sudden conditions.

My own attention was directed to this years ago in a case that I saw in a little baby in whom the heart was outside of the right nipple line with the lung on that side collapsed or solid, and the other lung markedly emphysematous. I think that probably was a congenital atelectasis. Outside of that and one other I had never seen a case of this sort until recently; and I wonder how many we have missed, because we have seen five or six of them in the last few years.

My attention was drawn to this especially by the paper of Leopold in the American Journal of Medical Science in 1924 in which he reported five cases that happened in post-operative conditions, all of them abdominal sections. All of these cases of Leopold's got well without any medical interference. That has not been our experience.

This condition occurs in a number of things. It is interesting to speculate whether there is one common cause for them all. To enumerate the conditions under which such a condition of acquired atelectasis or massive collapse of the lung has occurred, we can say that it was first described by Pasteur in connection with post-diphtheritic post mortems; secondly, that it occurs quite regularly in complete obstructions of a bronchus due to a foreign body; third, it occurs post-operatively, especially after operations on the abdomen, throat and in non-perforating wounds of the chest.

*A discussion presented before the 85th Annual Meeting, State Medical Society of Wisconsin, Madison, Sept., 1926. Stenographic report.

Bradley found during the war when his work was restricted to chest wounds that ten per cent of all the chest wounds that came to him had a collapse of the lung either on one side or on the other or on both sides. It occurs also in connection with pneumonia, especially if the child has a poor mechanism for manipulating the chest. It occurs also in pleurisy. It can occur with tumors, intrathoracic tumors, or with glands.

WHAT IS BASIC CAUSE?

On what single basis can one explain so widely varied a phenomenon? There is apparently one thing at the bottom of it all, namely, an obstruction of a bronchus. Whether there is a foreign body or something else in a bronchus, the bronchus is completely obstructed, the air is absorbed from the alveoli beyond that, and the lung to which it goes is shriveled and contracted.

In the post-diphtheritic cases, Pasteur offered the explanation that there was a paralysis of the diaphragm on one side and as a result of that the lung did not expand on that side and the air was removed from it. I believe that the explanation that Chevalier Jackson has recently offered is a much better one, and that is that in these cases there are inhaled into the lung with a result of obstruction of the bronchi, shreds of diphtheritic membrane, mucus and so forth that in the diphtheritic cases this cannot be properly expelled, and so forth, and that we have here obstructed bronchi just as we have in the case of any other foreign body.

This is corroborated by the experience which Jackson and his wonderful corps of assistants have had at the Bronchoscopic Clinic in Philadelphia where the mortality from post-diphtheritic bronchopneumonia has been reduced to one per cent by bronchoscopic cleansing of the bronchi of this material which is aspirated into them and which ultimately plugs the bronchi.

In cases of massive collapse that occur after tonsil or adenoid operations, the foreign body explanation is again the simple one and the only one that is necessary. Jackson recently reported, as you may have seen, some twelve cases in which collapse of the lung occurred following tonsil and adenoid operation because a piece of gauze or a little something fell into the child's throat and was inhaled during the operation.

We have had several cases in which there was nothing of that sort but in which the child undoubtedly inhaled pieces of adenoid tissue, clots of blood, and things of that nature, into the lung, and as a result of that had collapse or multiple areas of collapse of the lung.

There is another factor that enters into the case of the operation. We have a normal cough reflex; we get a foreign body into the throat or a mucus collection in the bronchi and we cough. The child or the individual that is under an anesthetic for the time being has his cough reflex in abeyance, consequently secretions, foreign bodies, pieces of tonsil or adenoid or anything of that sort may be sucked into the bronchus or into the trachea and is not expelled simply because the child does not cough.

What about the many cases that have been reported, perhaps more than of anything else, of collapse of the lung that occur after abdominal operations or non-perforating chest wounds? The essential thing again is undoubtedly an obstructed bronchus, but the things that favor an obstructed bronchus under those circumstances are pain in coughing, pain in breathing. An individual who has had an appendicitis or a hernia operation or a gall bladder operation is not going to cough any more than he has to right after his operation. Many of you probably know that from personal experience. The person who has a non-perforating wound of the chest is not going to cough any harder than he has to. He is not going to lie on that side; he is going to lie on the other side. As a result of all those things there is an imperfect respiration. That imperfect respiration favors the collection of mucus, sometimes on one side, sometimes on the other, and of purulent material, stagnation of the bronchi, and as a result ultimately obstruction of the bronchi in such a way that a collapse of the lung is produced.

The same thing is true of a diaphragmatic pleurisy, for instance, where a person will not cough any more than he has to, will not take a deeper breath than he has to. Under conditions of that sort there can ensue a stagnation of the secretions and so forth in the bronchi.

In pneumonia alone this can happen, especially in children who are rachitic. The rachitic child especially has not as good an expulsive power as the older individual has. The chest walls are weak, they cannot get rid of the mucus and secretions that collect, for instance, in a broncho-pneumonia or in any pneumonia or even a simple

bronchitis that causes an increase in the amount of secretion in the bronchi. One can get under those conditions an obstruction in the bronchi and a resulting absorption of air from the alveoli.

DIAGNOSIS RELATIVELY SIMPLE

The diagnosis of this condition is relatively simple if one has it in mind. It is not simple in cases in which there are only scattered areas of obstruction. It depends upon where the obstruction is, whether it is of a main bronchus or of only a small bronchus going to a small portion of a lung. If there are simply scattered areas, as I shall show you later, it is practically impossible to make a diagnosis by the ordinary clinical methods. The x-ray helps a lot. If, however, there is an obstruction of a main bronchus or if there is an obstruction of the bronchus to one whole lobe, the diagnosis is often very simple, clinically, and it is very easy with the x-ray ordinarily.

Clinically the things that characterize a massive collapse or extensive collapse are: Over one side there is dullness, and that dullness is accompanied by either an absence of breath sounds or just the opposite, a marked bronchophony and bronchial breathing, all of which can be present depending upon the anatomical conditions.

The thing, however, that is diagnostic, that is most characteristic, that is the thing upon which one makes the diagnosis, is that you have dullness, bronchial breathing or absence of breath sounds on one side and the heart drawn into the affected side. With a pneumonia the heart remains in the normal position: with an empyema or pleural effusion it is pushed to the other side; with a pneumothorax it is pushed to the other side; with a tumor it is pushed to the other side. In this condition you have an anomalous and pathognomonic finding and that is that your evidence of consolidation is on one side and the heart is actually drawn over into that side.

I want to emphasize just two or three points. I have talked about bronchoscopy. I think when one has a massive collapse of the lung there are only about two things which one can do, either wait for it to get well or call in a bronchoscopist. I believe there are many more cases in which a bronchoscopist can help than cases in which one can get relief from any other source. I would say further that if post-operatively one has a "pneumonic" condition, especially a "pneumonic" condition that is not perfectly evident, especially if the heart is pulled to one side, one ought to consider that a case of massive collapse of the lung, and I believe (Dr. Jackson has stated the same) that these cases in postoperative conditions are probably much more frequent than the eight or ten per cent that Pasteur had spoken of.

The first bronchoscopy that I ever saw was one of the most terrible things I have ever seen. Usually when they are done right they are relatively simple things. A bronchoscopy is done without an anesthetic. I don't know of anything in all medicine that requires more experience and more special technique than does bronchoscopy. I think ordinarily it would be a kindness to the child not to have a bronchoscopy done at all if it must be done by an inexperienced man.

Chronic Pyelitis in Infancy and Childhood*

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The average physician in general practice regards the clinical entity termed pyelitis as a relatively harmless infection in infancy and childhood, because he seldom sees a patient in whom symptoms of pyelitis do not yield readily to treatment. No doubt many patients are free from symptoms although bacteria persist in the urine; in the majority of cases, however, recovery from infection is uninterrupted. There are two types of common pyelitis. In the first unexplained fever is present without definite physical findings, save perhaps slight pallor and restlessness. The finding of large amounts of pus and bacteria in the urine establishes the diagnosis. In the second type pyelitis complicates such infections as otitis media, tonsillitis, furuncles, and so forth. These cases are so well known that it is unnecessary to go into detail regarding the clinical picture. Administration of large amounts of fluid and alkalization of the urine are usually effective in terminating the infection. Many patients recover without treatment.

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Another group of cases observed in infancy is characterized by recurring attacks of fever, persistence of malaise and pallor, extreme pyuria, and the great difficulty, in fact practical impossibility, of bacteriologic cure with the usual therapeutic measures. No doubt, a few cases of simple pyelitis run a severe course with repeated relapses and recurrences; these, however, are generally examples of inadequate treatment. The majority of the severe infections occur in the presence of an abnormality of the urinary tract which has led to inadequate drainage.

ILLUSTRATIVE CASES IN INFANCY

Case 1. A girl, aged ten months, had had severe pyelitis for six months. At intervals of from two to three weeks there had been recurrences of high fever with prostration and marked nutritional disturbance. The usual therapeutic procedures had had no effect. Cystoscopic examination revealed a large, gaping ureteral orifice on the left with marked dilatation of both ureters. On the right the catheter met an obstruction about 2 cm. above the ureteral orifice. Cultures of the urine from both ureters showed bacteria. Marked cystitis was present. About one-third of the urine, after standing, consisted of pus. Congenital anomaly of the ureters was diagnosed.

Case 2. A girl, aged three days, was found to have a mass in the lower abdomen with marked distention. On the sixth day cloudy urine full of pus and bacteria was voided. Large amounts of pus persisted in the urine in spite of alkalization, the administration of acriflavine and methenamine, and the forcing of fluids. During the first four months there were recurring febrile attacks, the temperature reaching 103°. The child's weight at the age of one year was 17 pounds. The bladder was usually palpable above the symphysis and the residual urine amounted to between 120 and 180 c.c. At the age of one year cystoscopic examination revealed diffuse cystitis, relaxation of the internal sphincter and normal ureteral orifices. No organisms were grown in the urine from either ureter. A roentgenogram of the kidneys, ureters, and bladder was negative. Cord bladder was diagnosed.

Case 3. A boy, aged six months, had been well until two weeks before examination, when a persistent cold had developed. The temperature had risen to 104°, accompanied by convulsions. The mother had noticed that the child seemed to strain when urinating. A catheterized specimen of urine showed albumin, grade 4, and pus, grade 4. For several months alkalization of the urine was tried, but without success. The child left the city and was not seen again until he was two and a half years, when a large spherical tumor was felt, filling the lower abdomen to above the umbilicus and decreasing in size on urination. Posterior urethral stricture was diagnosed and suprapubic cystostomy was performed.

These three cases indicate, as do the histories of many older children whose symptoms date back to infancy, that pyelitis in infancy may persist to later life because of some abnormality in the urinary tract. In view of the changes in the ureters and kidneys produced by damming back the urine, it is important that all infants with pyelitis that does not disappear under the usual therapeutic procedures should be subjected to complete urologic examination. If the abnormality is unilateral or the persistence of infection is due to stenosis or stricture relief is possible. After extreme dilatation of the ureter has taken place it is impossible to restore the normal state after the relief of obstruction.

The ease with which, even in severe uncomplicated cases, pyelitis can be cured in the course of

Fig. 1. Right hydro-ureter with hydronephrosis.

a month to six weeks is in direct contrast to the almost impossible task of eradicating infection in a congenitally abnormal urinary tract. Obviously every case of chronic pyelitis is not the result of some abnormality in the urinary tract, but it is almost certain that, if an abnormality exists, infections persist for months and years in spite of carefully controlled treatment. In our series of chronic cases, even when the infection had persisted for years, the administration of drugs was successful only in those cases in which there was no anatomic obstruction. If there was obstruction to the urinary flow the infection was influenced only in exceptional instances.

Fig. 2. Cystogram showing dilated left ureter.

In the older child several clinical forms of pyelitis occur. There is the typhoidal type in which the infection of the urinary tract presents no local symptoms and is manifested only by fever and malaise. The demonstration of bacteria and pus in the urine establishes the diagnosis. There is a second type in which there may be pain in the lower portion of the abdomen, burning and tenesmus on urination, and pollakiuria. In most of these cure follows the forcing of fluids, alkalization of the urine, or the use of urinary antiseptics. In many cases, no doubt, cure results without treatment. In a certain number of cases bacteriologic cure is not obtained, first because pyelitis is not recognized, second because of inadequate treatment, and third because there is some abnormality in the urinary tract as the result of infection, inflammatory stricture, stone, or congenital malformation such as double ureter, cord bladder and posterior urethral valves.

Under the typhoidal type of pyelitis the following cases illustrate how dependent diagnosis is on culture of the urine. In neither case was pyelitis suspected from the urinary findings, but cultures were made more or less as a routine.

ILLUSTRATIVE CASES

Case 4. A girl, aged fourteen years, was seen at the Clinic July 28, 1924. Pain in the left side had been present for years whenever she ran or played strenuously. Four years before, she had had an illness lasting from ten to twelve weeks which one physician had called "typhoid" and another "nephritis." She had been troubled with frequent urination since the age of four.

On physical examination there was tenderness of the left side of the abdomen about the level of the umbilicus. A roentgenogram of the kidneys, ureters, and bladder was negative. The urine showed pus, grade 1, and culture revealed innumerable gram-negative bacilli. On cystoscopic examination both kidneys were apparently normal, but subacute diffuse cystitis was present. Culture of the ureteral urine produced innumerable colon bacilli. The bladder was irrigated with mercurochrome. Hexylresorcinol and methenamine were administered. The first negative culture of the urine was obtained September 15.

Case 5. A girl, aged eleven years, was brought to the Clinic March 17, 1924, because of stomach trouble. There had been no definite onset but for three years she had felt heaviness and discomfort in the stomach, mostly in the lower portion of the abdomen. Her appetite had been poor. There had been no fever or vomiting.

Physical examination was essentially negative. The test meal showed total acidity 54 and free hydrochloric acid 36. Roentgenograms of the kidneys, ureters, bladder, and stomach were negative. The urine showed pus, grade 1, and innumerable colon bacilli and staphylococci were present on culture. The phenolsulphonephthalein output was 65 per cent. Fifteen grains of methenamine were given four times daily and as much fluid as possible. At the end of four days the urine was sterile and two negative cultures were obtained after medication was discontinued.

In a series of twelve cases[1] of chronic pyelitis which had persisted for periods varying from several months to five or six years, strikingly good results were obtained in a surprisingly short time with intensive methenamine therapy.

Definite distinction must be drawn between those infections which probably persist because of insufficient treatment and those which continue in spite of all therapeutic procedures because of abnormalities in the urinary tract. In the last group are found those cases due to cord bladder,

Fig. 3. Cystogram of a normal bladder.

Fig. 4. Cystogram showing cord bladder after voluntary effort to empty bladder.

stones in the ureters, bladder, and kidney, posterior urethral stricture, ureteral abnormalities including stricture, hydropyoureter, dilated ureter, and abnormalities of entrance into the bladder from the ureter. In practically all these cases, in spite of intensive general, as well as local, treatment, it was impossible to eradicate the infection.

ILLUSTRATIVE CASES

Case 6. A girl, aged seven years, was brought to the Clinic August 25, 1924, because of pyelitis which had been present for six years. Examination disclosed slight tenderness over the kidneys. The urine contained pus, grade 2. The blood urea was 30 mg. for each 100 c.c. The phenolsulphonephthalein output was 50 per cent. The roentgenogram of the kidneys, ureters, and bladder showed bifurcation and sacralization of the fifth lumbar vertebra on the right. Culture of the urine disclosed innumerable colon bacilli. Cystoscopic examination revealed right hydro-ureter with hydronephrosis (Fig. 1). Following a month of treatment with methenamine right nephrectomy and right ureterectomy were performed. A small renal sac with two large dilated ureters was found on the right. At present the child is doing well and there are no signs of urinary infection.

Case 7. A girl, aged three years, was seen at the Clinic in January, 1923. When she was six months old pus had been found in the urine following dysentery. There had been no chills or fever. The urine showed pus, grade 3, and innumerable colon bacilli on culture. After fluids had been forced and methenamine administered for about two weeks the culture of the urine was negative. In August of the same year the infection recurred, but two negative cultures were obtained after about two weeks of treatment. In February, 1924, the child was brought back with the same complaint, and innumerable colon bacilli were again found in the urine and continued to be found in spite of all treatment. Cystoscopic examination in April revealed left renal infection, the left ureter opening into the vesical sphincter. Cultures in February, 1925, showed innumerable colon bacilli. The infection still persists.

Case 8. A boy, aged ten years, was brought to the Clinic January 31, 1921, because of incontinence of urine which regularly contained pus. Dribbling had been present since birth. At five years of age he had had the first attack of pain over the bladder, fever, and retention of urine. Physicians believed it was due to cystitis. Such attacks had recurred periodically.

The urine contained pus, grade 4. The phenolsulphonephthalein output was 65 per cent. A roentgenogram of the kidneys, ureters, and bladder was negative save for spina bifida occulta and absence of the coccyx. Cystoscopic examination showed posturethral stricture and cystitis, grade 3. Suprapubic cystostomy with dilatation of the stricture was performed.

One year later the urine still contained pus. The phenolsulphonephthalein output was 50 per cent. Cystoscopic examination showed that the bladder had a small capacity. The left ureter was enormously dilated and tortuous (Fig. 2). There was possibly slight dilatation of the right ureter. Large amounts of fluid and methenamine were advised and after five days the culture of the urine was negative. The urine continued free from pus but not entirely free from bacteria. Later reports indicate that the child is in good general health, but the infection still persists.

Case 9. A boy, aged four years, was brought to the Clinic November 16, 1925, because of pus in the urine with retention, a condition which had persisted for about three years. The first attack had been accompanied by fever, loss of appetite and listlessness. Attacks had recurred frequently. For the last few months the bladder

Fig. 5. Right ureter dilated.

Fig. 6. Stone in the right ureter.

had been catheterized twice daily and the residual urine had amounted to about 120 c.c. each time.

Urine contained pus, grade 3. The phenolsulphonephthalein output was 65 per cent. The blood urea was 24 mg. for each 100 c.c. Culture of the urine disclosed innumerable colon bacilli. A roentgenogram of the kidneys, ureters, and bladder revealed spina bifida of the first sacral vertebra. Cystoscopic examination revealed a markedly dilated atonic bladder with no reflux (Figs. 3 and 4). Methenamine and ammonium chloride were advised and the boy returned August, 1926, at which time the urine was found to contain pus, grade 2. The residual urine amounted to 60 c.c. The blood urea was the same as before. The phenolsulphonephthalein output was 60 per cent. Innumerable colon bacilli were again found on culture of the urine. Cystogram showed a large atonic bladder without trabeculation. There had been no progression of the infection.

Case 10. A girl, aged two years, was brought to the Clinic because of attacks of fever accompanied by frequent urination and pyuria, for the last fifteen months. Vaccine treatment had been without benefit. The urine contained pus, grade 2. A roentgenogram of the kidneys, ureters, and bladder was negative. Alkalis and an autogenous vaccine were recommended. The child was brought to the Clinic again at the age of nine years. The mother had believed the infection had disappeared until the last year when symptoms returned and pus was found in the urine.

Examination disclosed pus, grade 1, in the urine, and innumerable colon bacilli on culture. The phenolsulphonephthalein output was 45 per cent. The residual urine amounted to 25 c.c. Roentgenograms of the kidneys, ureters, and bladder were negative. The blood urea was 18 mg. for each 100 c.c. Several cystoscopic examinations demonstrated that the bladder was normal. The function of both kidneys seemed good. The right ureter was dilated throughout (Fig. 5). Methenamine and hexylresorcinol were given; cultures of the urine continued to show bacteria, but no pus. In the next year only one attack occurred. She had had no pain or burning on urination. Medication had been continued throughout the year. Clinical and laboratory findings were practically the same as before, except for the fact that the urine from the left ureter was essentially negative, whereas that from the right ureter contained innumerable colon bacilli.

Case 11. A boy, aged seven years, was brought to the Clinic because of hematuria. The mother stated that he had seemed listless and pale for about two years. Occasionally he had complained of pain in the right side. Three months before, he had had an acute attack of pain with fever and vomiting. At that time the urine contained blood, pus, and albumin, and colon bacilli on culture. Pain and hematuria had continued.

On the first examination neither blood nor pus was found in the urine. The phenolsulphonephthalein output was 35 per cent. The blood urea was 18 mg. for each 100 c.c. A roentgenogram of the kidneys, ureters, and bladder revealed a shadow of the lower right ureter (Fig. 6). By cystoscopic examination a stone, 4 by 2 cm., was located in the lower portion of the right ureter. Right ureterolithotomy was performed. A few days later pus was found in the urine, which yielded colon bacilli on culture. Methenamine and ammonium chloride were advised. The boy left before sterile urine was obtained and there have been no further reports.

Case 12. A girl, aged six years, was brought to the Clinic in May, 1924, having complained for three years of severe pain during and immediately following urina-

Fig. 7. Stone in the bladder.

tion. At three years of age she had had scarlet fever and during convalescence she began to have trouble passing urine. Attacks of frequent painful urination had continued. The urine had contained pus for some time. The bladder had been washed out but without benefit.

On physical examination questionable fullness over the bladder was found. Rectal examination was negative. The urine, which contained pus, grade 3, showed innumerable staphylococci on culture. The phenolsulphonephthalein output was 30 per cent. The blood urea was 25 mg. for each 100 c.c. A roentgenogram of the kidneys, ureters, and bladder showed a large stone in the bladder (Fig. 7) which was removed by suprapubic cystostomy. On her dismissal the culture of the urine showed only streptococci, probably due to contamination.

DISCUSSION

In a case of chronic pyelitis in an infant or child the diagnosis should first be definitely established by culture of the urine, and second, depending on the length of time that the infection has persisted and the therapeutic measures which have been used, other medical procedures should be attempted before complete urologic examination is undertaken. Third, the examination of the urinary tract should consist of making roentgenograms of the kidneys, ureters, and bladder, and determination of the blood urea, the phenolsulphonephthalein output, and the amount of residual urine. Fourth, if these are approximately normal, cystoscopic examination should be carried out with catheterization of both ureters, so that ureteral urine may be obtained for microscopic examination and culture. Pyelogram of one or both ureters may be made to determine the site of the infection and abnormalities of the urinary tract.

In our series of 150 cases of pyelitis seen in the last five and a half years the association with abnormalities of the urinary tract in forty-six accounted for the chronicity of the infection (Tabulation). The treatment of chronic pyelitis is not encouraging but our results in cases of chronic pyelitis without anatomic lesions warrant preliminary trial, to determine whether or not the complete urologic examination should be made.

We have found most useful the combination of ammonium chloride and methenamine, advocated by Helmholz and Millikin. By the administration of from 30 to 60 grains of ammonium chloride each day the urine is rendered acid to a hydrogen-ion concentration of $pH5$ to $pH5.5$; the methenamine is given in doses of from 30 to 90 grains daily, depending on the age of the patient. If the infection does not disappear the dosage is gradually increased to tolerance as denoted by marked frequency and hematuria. In most cases the infection disappears in from one to three weeks and, if a thorough trial of this treatment does not produce bacteriologic cure, it is important to proceed with complete urologic examination. Surgical or other treatment will depend on the urologic findings. If the lesion is unilateral and the renal function low removal of the offending kidney and ureter is indicated. If the ureteral dilatation is only slight and the renal function good, prolonged medical treatment with pelvic lavage should be attempted. Indications for removal of stones, valve-like obstructions, and dilatation of strictures are evident.

The most difficult group to treat is probably that made up of cases of faulty innervation of the bladder, because of the constant pressure of infected urine in the bladder. If the bladder is regularly emptied, the back pressure and infection can be kept out of the upper portion of the urinary tract but the probability of infection is always present. Transplantation of the ureter may offer some relief if infection of the ureter and pelvis has taken place. The great majority of these cases with anatomic lesions show good renal function and relatively few symptoms, but there is the constant danger of pyelonephritis which may prove fatal.

PYELITIS ASSOCIATED WITH ABNORMALITY OF THE URINARY TRACT

Cases seen in last five and one-half years	150
Abnormality	46
Cord bladder or atonic bladder	17
Ureteral anomaly	10
Dilated ureter	6
Urethral stricture	4
Anomaly of ureteral orifice	4
Duplication of ureters	2
Vesical stone	2
Ureteral stone	1

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DISCUSSION

Dr. Thomas Willett (West Allis): In the month of September in the town in which I live we had a mild epidemic of infectious nasopharyngeal disease. I cannot tell how many we have seen in our office, but out of those we have seen twelve acute cases of pyelitis. None of these in culture showed any colon bacillus, but all staphylo-streptococcic infections. Whenever a case of this nasopharyngeal disease dragged a little longer than it should and the temperature didn't go down in the

usual way, we sent a specimen of urine to the technician, and in most of these cases we found a pyelitis. The children all apparently cleared up, but keeping in mind the dictum of Bruce at Toronto that there is no cured acute pyelitis but all of it is pyelonephritis, wherever we can influence the mother to keep up the watchfulness and bring them to the office we are keeping track of them. Practically all of them now are showing sterile urine.

The thing that has impressed us more than anything else is that acute pyelitis in children is much, much more common than is generally recognized, and so many of them are only recognizable through the urine. Most of these children showed no particular urinary symptoms at all except that the fever did not go down as it should have, and so we sent the urine to the technician for examination.

We have been impressed, in the past few years, that we have very little acute pyelitis in children without "nose-throat disease." We have not seen *any* of these acute pyelitis cases except where there *has been* nasopharyngeal involvement of some kind. We are not speaking, of course, of the chronic types. After all, acute pyelitis in children is a very, very common thing if it is kept in mind when making the diagnosis.

Pyelitis in Pregnancy*

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Pyelitis as a complication of pregnancy has been recognized for nearly a century, but the first comprehensive paper on this subject was that by Opitz in 1905. Since that date so many articles have appeared bearing upon its different phases that these important facts may be assumed to be established. The condition manifests itself by chills, fever, pain in the back and along the ureter, associated with varying degrees of dysuria and frequency of urination. The right side is involved more frequently than the left and most of the cases occur in the fifth or sixth month of gestation, although we have had cases in all periods from first month to last. The organism usually found upon culture is the bacillus coli. The essential confirmatory diagnostic point is the finding of pus in a catheterized specimen of urine.

The important problem confronting us now, is not so much the diagnosis, but rather the treatment of this condition. One must admit that any continuous high temperature or infection during pregnancy is not only dangerous to the mother, but also has a profound effect upon the foetus and may be the exciting cause of a miscarriage. Our efforts then should be directed to restoring the mother to a normal condition by the most rapid, conservative, and safe methods at our disposal.

In order to intelligently direct treatment one must have a clear understanding of what pyelitis is and what conditions maintain in the urinary tract during pregnancy. Pyelitis means an inflammation of the pelvis of the kidney. This is not a true pathological or anatomical term, but is a clinical phrase for we practically never have an inflammation that does not go beyond the confines of the pelvis. The diagnosis pyelitis must be differentiated from a calculus pyonephrosis, a surgical kidney, or a tuberculosis. This can be accomplished by a careful history, physical examination, bacteriological studies, roentgenological findings, and cystoscopic examinations. We have not found it necessary to make pyelograms, but practically all of our cases had x-ray films made to exclude the possibility of calculus formations.

Simple pyelitis is almost universally recognized as being a secondary infection, and, in most instances, has its origin in foci of infection in the upper respiratory tract and its accessory sinuses or in infected teeth. Rosenow believes the first lesion is in the kidney parenchyma while Hunner feels a ureteritis is the essential urinary tract lesion. Franke has shown that there is a lymphatic communication between the colon and the capsule of the kidney. The well recognized frequency of chronic constipation in pregnant women may be a factor in bringing about an infection in the urinary tract.

We have had an opportunity to study forty-five cases of pyelitis in pregnancy in the hospital. A careful review of their past histories shows that about fifty per cent gave a quite definite history of urinary disturbance before pregnancy.

Helmholz has called our attention to pyelitis in childhood and the frequency with which this is not recognized. Many investigators feel that pyelitis in pregnancy may be a flare up of this long standing quiescent infection of childhood. DeLee states that in two-thirds of the post mortem examinations made upon women during pregnancy or the puerperium, dilatations of the ureters, especially of the

*Read before the 85th Annual Meeting, State Medical Society of Wisconsin, Madison, Sept., 1926.

right side, were found. Israel quotes the investigations of Hiersch who analyzed three hundred autopsies performed upon women in pregnancy and puerperium and found thirty per cent showing dilatations of the ureters. He also is of the opinion that this condition is a primary one and not a sequence of the infectious process. Kretschmer believes that in eighty per cent of normal pregnancies there are dilatations of the ureters. Hunner is of the opinion that most of these cases are due to ureteral strictures which antidate the pregnancy and he disagrees with those who feel that the dilatation does not exist after delivery. This is not the time or place to discuss ureteral stricture, but in spite of the tremendous criticisms that were thrown at Hunner, he has stood firmly upon his convictions until now his ideas upon stricture are being accepted by an ever increasing number of prominent urologists. Our own clinical results convince us that he is correct.

If a ureteral stricture is not the basis for this condition, which Israel calls "the typical example of a dilatation pyelitis," what does produce it? Many may feel that pressure of the pregnant uterus upon the ureters causes the stasis. Other feel, that as the uterus enlarges, there are changes in the base of the bladder which effect the ureteral orifices; while some believe that as the uterus so frequently twists toward the right side of the body during pregnancy it produces a pulling on the connective tissue around the ureter and causes obstruction. We must admit that under some exceptional instances there may be pressure of the foetal head upon the ureters at the pelvic brim that could cause stasis. We have never seen such a case and we believe they are very rare.

One of the arguments advanced in favor of the theory regarding pressure of the uterus is the fact that these cases in most instances are decidedly improved as soon as the uterus is emptied. Anyone who has had any experience with ureteral strictures in women realizes that the pain and discomfort of these patients are always most severe during menstruation when there is marked engorgement of the pelvic vessels. This same condition would hold true in pregnancy and would be relieved after delivery. Schwarz, DeLee and Israel agree with Hunner that these conditions cannot be the cause of the stasis. Our clinical results point to some intra-ureteral obstruction and not to any outside pressure. Twenty-eight cases of this series or fifty-six per cent required only one catheterization of the ureter. It is impossible to believe that the mere passage of the ureteral catheter could dislodge a pregnant uterus or change any other anatomical arrangement. The only possible effect it could have would be to relieve some intra-ureteral obstruction and establish good drainage.

STASIS IN URINARY TRACT

The essential point that we wish to emphasize is that there is a decided stasis in the urinary tract during pregnancy. It is now well established that it is almost impossible to produce an infection in the urinary tract without some form of obstruction. Urologists are all agreed that the essentials in the treatment of obstructions in the urinary tract are first to secure adequate drainage and second to remove the obstruction.

Therefore the main object of our treatment should be directed toward securing adequate drainage to overcome this stasis. We believe that the mild cases of pyelitis can be relieved by rest in bed and the introduction of large amounts of fluids. We feel that medication is of secondary consideration. We have obtained equally good results from urotropin with sodium acid phosphate or from an alkaline therapy such as citrocarbonate. We prefer the latter and give it in teaspoonful doses in a glass of water every three or four hours, night and day. Probably the introduction of this amount of fluid is the most important factor.

All of our cases have been treated in this manner for at least a week. If the symptoms do not clear up under this medical treatment we use the cystoscope and catheterize the ureter. We cystoscope at once those cases that are unusually toxic and those that have severe colic. The relief obtained by dilatation in those cases that have severe pain from a hydronephrosis is most gratifying. In some of our early cases we used only a number five or six catheter, but we had to repeat the catheterization in many instances. Now we use as large a catheter as possible at the first treatment (using either a number nine or ten Blasucci catheter). We irrigate the pelvis with one per cent mercurochrome, but feel that the dilatation is the real important factor. If the symptoms persist and the patient is very toxic, an indwelling ureteral catheter is used and this should be at least a number eight in size. It is irrigated frequently to be sure that it is not plugged. It may be left in place for days or weeks.

Our results have been very satisfactory. Those with severe pain have been relieved at once. Those with high temperature and chills have returned to normal within twenty-four hours in most instances. We have not attempted to cure the pyelitis during pregnancy, that is another problem. In ten cases that we examined in from six months to a year after delivery all showed some pus cells in the urine.

We have had four miscarriages in this series. One occurred on the day of the treatment in a patient who insisted upon making a journey by train to her home a few hours after her treatment. One occurred twenty-four hours after an indwelling catheter was inserted into the ureter. This was the most toxic case we had and was associated with a pneumonia. We believe this toxemia was the main factor in precipitating the miscarriage. The other two occurred two months after treatment.

We are convinced that the catheterization relieves the obstruction of the ureter which produces the stasis better than any other known treatment. We have never had to resort to any surgical measures, such as nephrotomy, and we strongly condemn the induction of labor to correct this condition because we know that the patient can be relieved without terminating the pregnancy.

CONCLUSIONS

Pyelitis in pregnancy must be considered as a secondary infection which is dependent upon a stasis of the ureters. We believe this stasis is due to some form of intra-ureteral obstruction or stricture and is not due to any pressure from the gravid uterus.

Treatment is to secure adequate drainage. The mild cases can be relieved by rest in bed and forcing fluids. The other and more severe cases should have the ureter dilated with large catheters.

The results are satisfactory. The procedure is safe. Surgical intervention is practically never indicated and there is no justification for the induction of labor.

DISCUSSION

Dr. W. J. Carson (Milwaukee): I should like to subscribe to practically everything that Dr. Sexton has told us, and I should like to show some lantern slides in a study of autopsy cases at the University of Maryland for the past five years (up to July of this year), with sixteen cases of pregnancy which came to autopsy and were studied carefully.

When I opened the abdomen the ureters could be seen to be dilated in each case on the right side, and in the majority on the left. Measurements were made before any organ was disturbed. In several of these cases where the pregnancy was present, upon raising the uterus forward off of the ureter, the pelvic portion of the ureter was seen to be collapsed and immediately was distended by urine, the urine by gravity going down from the abdominal spindles. These organs were removed in toto and studied by x-ray, gross and microscopical examinations.

Of these sixteen cases the first five are primiparas. The average capacity on the right side varies from twenty to a hundred c.c. with an average of 52.6 c.c. On the left side it varies from six to eighty c.c. with an average of thirty-four. There were four cases which did not show a capacity of above thirteen c.c. on the left side, and you will note that in three of these they were not full term.

The multiparas show a definite histological change in contrast to the primiparas. The first case is of special interest, showing twenty c.c. on the right side, eight on the left, and at this point immediately beneath the right iliac artery a No. 6 catheter with a No. 10 bulb met with obstruction. This is what I take to be an early stricture, showing an increase of fibrous connective tissue; those are young fibroblasts, plus small round cells, and occasionally polymorphonuclear cells with new formed blood vessels. Sections taken from above stricture show the marked edema, without the new formation of blood vessels. You can see here some very small new formed blood vessels and a large number of new formed connective tissue cells, with marked edema of the mucosa.

The second case shows twenty-two c.c. on the right with six on the left, and you note there is some dilatation in the pelvic portion as well.

This is from the right ureter of Case No. 2, showing marked edema, marked infiltration. The left side shows practically the same thing with marked perivascular infiltration of these cells, and marked edema present.

This is of special interest and is the only case diagnosed clinically. It was treated as a case of pyelitis with pregnancy and labor induced in the thirty-fifth week. Two weeks from the time of delivery I performed an autopsy and took this pyelogram immediately after removing the organs. Note the stricture six cm. down on the left side.

This is a microphotograph of that stricture.

This is another case of multipara. In the multiparas you find all of the acute changes, the edema, the cellular infiltration, and so forth.

Here is a gross specimen of a case which died from eclampsia, eighty c.c. to the right and fifty to the left. Microscopically there was a little more infiltration in the ureteral wall from the bladder to the pelvis than usual.

A few cases were studied carefully from two months to seven years after delivery. You will note that the capacity on the right side varies from fifteen to seventy c.c., with an average of thirty-five, and on the left from ten to forty c.c., with an average of 11.6 c.c., one case showing a stricture. This shows a case six years after the last delivery, a long spindle type of stricture start-

ing four cm. below the ureteral pelvic juncture. In these cases several years after you find a marked increase of fibrous connective tissue with a few round cells around some of the blood vessels.

From a study of these autopsy cases I have concluded that pregnancy causes a physiological dilatation of the right ureter, and bilateral in the majority of cases, with a secondary inflammatory reaction in the ureteral wall, and in the event of pyogenic bacteria being carried to the kidney and ureter by the blood stream or by lymphatics, an acute inflammation will follow upon the ureteral wall and this will be followed by scar tissue and stricture may be the result. I think this is where Dr. Sexton and I perhaps differ just a little. I feel that the pressure is the primary part in producing this change in the ureteral wall as the cause of the edema, as the cause of this secondary inflammatory reaction.

Symptomless Hematuria As An Early Sign of Bladder Tumors*

BY DANIEL N. EISENDRATH, M.D.
Chicago

This paper is written with but one object in view and that is, to impress upon you as general practitioners, first, the fact that in three-fourths of the cases of bladder tumor, hematuria is the first and often only symptom and second, that if we wish to improve the present unsatisfactory results of treatments of such tumors that we must have better cooperation on the part of the physician who is consulted because a symptomless hematuria has appeared for the first time or has recurred a number of times.

I do not propose to discuss either the sources of hematuria in general nor the more technical methods of diagnosis of bladder tumors and their subsequent treatment. The first of these was fairly well covered in a recent contribution[1] and then again it would be superfluous to burden you with questions such as the cystoscopic recognition of the different forms of bladder tumors and the statistical end results of this or that method of therapy. Both of these last two are today in the province of the urologist, a worker equipped with special instruments and trained in the diagnosis and treatment far better than any general surgeon.

PATHOLOGY OF BLADDER TUMORS

In order that you may understand why hematuria is the first symptom of bladder tumors and also why such a hematuria is so seldom accompanied by other symptoms, it is necessary to have some knowledge of the different forms of these neoplasms.

About 90 per cent of all bladder tumors arise from the mucous membrane, i. e., are of the epithelial type (Fig. 1). The other 10 per cent are of connective tissue or of embryonic origin. For practical clinical purposes we may leave aside this 10 per cent because they are of chief interest to the urologist. Let us, therefore, consider the other 90 per cent. These are the types with which you will come in contact in every day work.

There are three forms or types of neoplasms of epithelial origin. They are:

1. The simple benign papilloma.
2. The papillary carcinoma.
3. The infiltrating type which resemble carcinoma as seen on the lips, tongue and similar squamous cell epithelial structures.

Of these three, the first two are the most important to understand. Imagine a skin papilla suddenly growing towards the superficial epithelial coverings just as the finger of a glove is unfolded thus carrying these epithelial layers along as its surface covering. Imagine further that such a skin papilla after extending beyond the level of the immediately adjacent skin should begin to branch so that instead of a simple projection (B) we should see a single stalk or pedicle arising from the corium of the skin having a variable of branches or offshoots, all supplied with vessels from the pedicle and each branch as well as the pedicle covered with epithelial cells arranged quite regularly. Now this occurs in the epithelial lining of the bladder just as we have attempted to visualize such a change in the more familiar cutaneous covering of the body.

Imagine further that instead of a single stalk or pedicle with regularly arranged epithelium covering its many branches or villi or fronds as we term them in the bladder, the epithelium begins to proliferate in an atypical irregular manner, that it begins to invade the stalk or pedicle and multiply so as to extend into the submucous layers from which the pedicle with its epithelial covering, took its origin. Imagine further that the individual branches begin to coalesce and as a result

*Read at the Tenth District Meeting of the Wisconsin Medical Society held at Marshfield, Jan. 14, 1927.

the pedicle is so short that one can no longer distinguish it.

Now how can we interpret these more complicated changes? The simple pedicle with its many branches all with blood vessels in their noninvaded interior and covered with regularly arranged epithelium represents the benign type of tumor to which the term papilloma is given. It occurs singly or in multiple form in the bladder and as we shall see later if recognized early enough yields to a comparatively simple method of treatment, viz., fulguration or implantation of radium or both.

The more complex form in which the epithelium has begun to proliferate in an atypical manner, has invaded the supporting connective tissue of its fronds or branches and has resulted in the coalescence of adjacent ones, and represents the type of neoplasm known as papillary carcinoma which is far more difficult to treat and not only tends to recur after the simpler methods of treatment mentioned above but invades the wall of the bladder at a comparatively early stage.

The third form which I have compared above to the carcinoma of the lips, tongue and similar "pavement" (squamous) celled types does not occur nearly as often in the bladder as do those forms in which papilla formation is the outstanding feature. It protrudes but little into the lumen but invades the wall of the bladder at a comparatively early stage so that not only from the standpoint of treatment but also of prognosis it is a far less favorable form of neoplasm.

I have attempted to describe these three basic types of epithelial tumors in as simple a manner as possible because the average physician who first is consulted on account of a hematuria should realize that the earliest type is the simple papilloma. If a cystoscopic diagnosis can be made before it has undergone malignant changes, i. e., has been converted into a papillary carcinoma, what a vast difference it would make in our present-day unsatisfactory end results.

As stated at the beginning of this paper about 90 per cent of all bladder tumors belong to one of these forms of epithelial neoplasms. Can we not hope that with a better visualization of the underlying pathology as just outlined that we may be able to have a larger number of simple papillomata referred for examination?

DIAGNOSIS

In the opening paragraph of this paper the statement was made that the first and often only symptom for a long period, is hematuria. Statistics from nearly every large urologic clinic corroborate this assertion. Young in his recent book states that of 541 cases cited by Clado, Geraghty and Verhoogen, hematuria was the initial symptom in 404 or 75 per cent. This is the experience of nearly every urologist who has occasion to see a large number of cases. At a later stage in these 75 per cent and at an earlier one in the remaining 25 per cent symptoms of bladder origin such as frequency, pain on urination, dysuria, etc., appear to a variable extent. The greater the degree of infiltration of the bladder wall, the more do frequency and pain stand out in the clinical picture. The same is true when ulceration as the result of necrotic changes in the tumor and also when more or less generalized cystitis supervene.

Metastasis apparently occurs much less commonly in cases of bladder than in those of prostatic carcinoma. In the latter, symptoms due to metastases in the bony structures (spine, pelvis, femur) are often the reason why relief is sought, so that a bilateral sciatica, for example, above middle age should direct our attention to a possible carcinoma of the prostate.

This is not true of bladder tumors which are much more apt to invade the immediately adjacent structures, and even this at a comparatively late period.

Our first duty as urologists, therefore, is to search for the cause of the hematuria, frequency, or pain on urination by a complete urologic study. Examination of the urethra and bladder with our special instruments will enable one to determine very quickly whether the source of the hematuria is in the upper or lower urinary tract.

It is a far more simple task to determine that the source of the symptoms, especially of the hematuria, is in the bladder than to say whether the neoplasm is still benign or has undergone malignant changes. In spite of rapid advances made in this direction, except in the case of the simpler forms of papilloma, one is obliged not infrequently to depend on the clinical course of the individual case rather than on the cystoscopic appearance or even on the results of the examination of portions removed for microscopic study. I have attempted to avoid technical details in this

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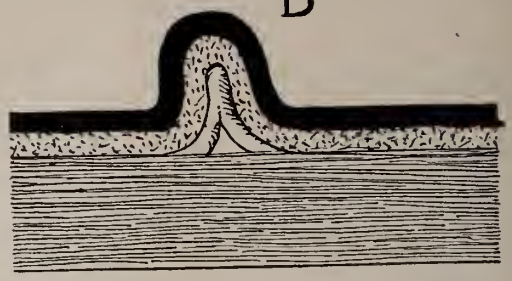
B



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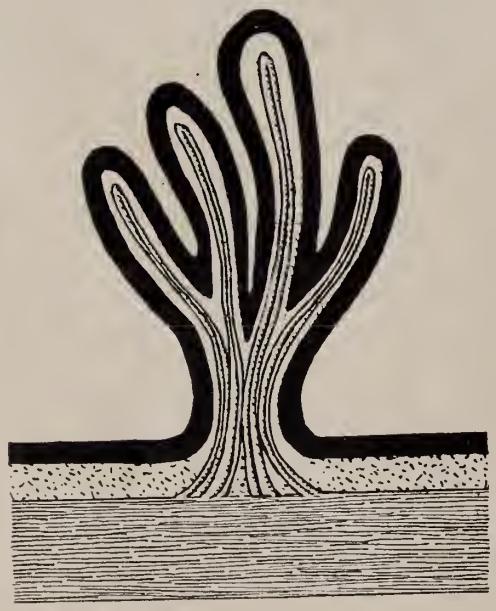

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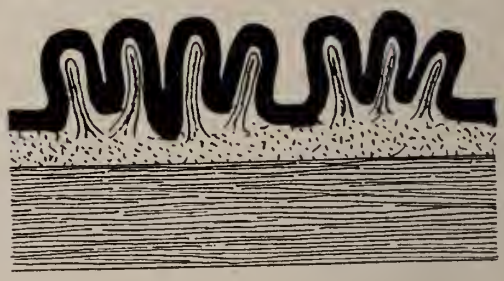

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paper and will not enter into a description of the differences cystoscopically between the various forms of benign and malignant neoplasms.

For purposes of treatment it is advisable to regard every bladder tumor as potentially malignant until the clinical course proves otherwise.

TREATMENT

I regret to be obliged to acknowledge that for the majority of cases we are not yet masters of the situation and hence our end results, i. e., five year cures[2], are still relatively unsatisfactory. This is due to a number of factors which you can more readily comprehend if you have followed what was said about the pathology of the epithelial types of bladder tumors. These stumbling blocks to better end results are the following:

1. First and foremost, the cases are usually seen by the urologist at too advanced a stage to institute more than either palliative treatment for the relief of pain, the effects of necrosis, etc., or one undertakes more radical measures with but little hope of a favorable end result.

2. There is a great tendency for even the simpler papillomatous forms to recur at the site of their original appearance or at other parts of the bladder. This recurrence is often due to the fact that an erroneous diagnosis of benign papilloma was made and the initial method of treatment was not adequate for a tumor which was already malignant.

3. Even when a cystoscopic diagnosis of papillomatous carcinoma has been made, it is impossible even at operation to determine the degree of involvement (a) of the wall of the bladder and (b) of the regional lymph nodes which drain this viscus. As in other parts of the body we have learned that clinically there is much difference in the malignity of carcinoma. Broder's classification is a most valuable one for determination of this factor.

4. Some of the cases are of the squamous celled type primarily and hence spread so rapidly in the wall that nothing short of a total cystectomy would be of avail.

5. In the case of the breast, uterus and similar cancers in which radical operations are being performed, we are not confronted with the duty of providing a mode of exit for such excretory ducts as the ureters. In some of these cases of bladder cancers, the reimplantation of the ureters into the bowel or into the skin is being attempted as a palliative measure. There is, however, a tendency at present, to do this as a preliminary step in total removal of the bladder. Perhaps this method will improve our statistics in the future.

In spite of the apparently pessimistic viewpoint which has been expressed thus far, the situation is not hopeless if we can secure better cooperation, i. e., earlier reference of cases either presenting hematuria as an initial or recurrent symptom or as cases with the usual symptoms (pain, frequency, etc.) of a cystitis which does not yield to treatment. We are able to cure a fairly large percentage of simple or even benign papillomata with endovesical fulguration or the introduction of radium emanation seeds (with the aid of special apparatus), i. e., without operation.

The most important feature of such cases is, however, that they must be reexamined cystoscopically at short intervals for a long period in order to treat recurrences before too much headway has been made. Secondly, every effort should be made to eliminate bladder neck or urethral obstruction which in my experience is often found in cases of vesical papilloma.

Although fulguration (application through the cystoscope of the high frequency spark) destroys the blood supply and tumor tissue itself in cases of small papillomata (up to 1 cm. diameter).

Its endovesical application is contraindicated in the case of a growth which is larger than a cherry. For such cases I now employ the transvesical method, i. e., do a suprapubic cystostomy, and use much stronger currents (higher amperage) with a larger electrode to destroy the tumor by this electrocoagulation method[3] (surgical diathermy). Whether the tumor has a pedicle or not we begin at the surface and continue to apply the button electrode until the area in the bladder wall is reached from which the tumor arises. We continue to burn until this base has been thoroughly treated, being careful not to perforate the bladder

Fig. 1. Diagrammatic representation of mode of origin of various types of bladder cancer.

A. Normal bladder wall. Epithelial layer shown as solid black line.

B. Elevation of epithelial layer (mucosa) with its underlying submucous layer and blood vessel.

C. How a simple (benign) papilloma with long narrow pedicle evolves from B.

D. Multiple sessile (benign) papillomata arising in similar manner.

E. A pedunculated or sessile benign papilloma has undergone malignant changes by invasion of pedicle as well as submucous and muscular coats of bladder wall.

F. How an infiltrating (non-papillomatous) cancer invades all of the coats with but little protrusion of tumor into the bladder lumen.

wall. Although we[3] are not yet prepared to report our five year end results the number of apparently completely healed cases is rapidly increasing.

This method of surgical diathermy has entirely supplanted, at least in our hands, the method of resection of the tumor and its base. We have also discontinued the endo- or transvesical surface application or insertion of radium (in the form of the element or emanation) in such cases.

Frequent reexamination is the keynote of success in these cases as in simple small papillomata. No one can determine in many of these cases of large papillomata with soft, still, well-marked, fine villi either cystoscopically or by examination of small fragments removed with a cystoscopic "specimen taker" whether the growth is still benign or malignant, but we take no chances and electrocoagulate them thoroughly transvesically as stated above.

For the outspoken papillomatous carcinoma[4] with cauliflower like more or less solid surface the outlook is not so good. We electrocoagulate these thoroughly when they are located elsewhere than in the dome (vertex) of the bladder. In the latter instance the writer believes that resection is feasible provided that no evidence of metastasis can be found. Although Judd in a recent contribution from the Mayo clinic is inclined to conclude from a study of their end results that resection for cancer of the bladder has yielded the best end results, we are not inclined to share this view. The primary mortality of resection is still too high to justify its general application.

For in operable cases, iliac ureterostomy affords relief to the almost intolerable pain on urination, etc., more rapidly and safely than any other method. Some equally good results in inoperable cases with deep therapy have been recently reported by Waters, Schmitz and others. A possible stricture of the ureters and more rapid metastasia following such deep therapy must be always borne in mind.

In closing let me again urge the duty which you owe the patient of regarding every hematuria as worthy of immediate investigation by some urologist.

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2. Many cases are reported as cured after this or that method of treatment after a period of observation of one, two or even three years. One must apply the same period, viz., five years as is now almost universally used in cases of operable breast, uterine and other forms of cancer.

3. Dr. G. Kolisher deserves the credit for being the pioneer in this method of treatment at the Michael Reese Hospital and also for perfection of our technic.

4. Geraghty always made the distinction between malignant papilloma where the tumor projected into the lumen and papillary carcinoma where it did not. We call both of these, simply papillary carcinoma.

THE JOURNAL CLINIC

Diagnostic Problems

BY L. M. WARFIELD, M.D.
Milwaukee

In the March issue we presented the history of a girl of nineteen who had attacks of jaundice and bloody urine. The slight jaundice was always present but showed fluctuations in intensity. Since her menstruation she has had several attacks of profound anemia with bloody urine. On physical examination she had an enlarged spleen with hemoglobin in the urine.

DISCUSSION

This case has some very peculiar features, the most remarkable of which are the sudden attacks of hemoglobinuria which have apparently at times been brought on by the administration of iron and which have a remarkable diurnal character. The fact that an attack is brought on by iron was confirmed by the attending physician with whom I saw the case, and the peculiarity of the hemoglobinuria, marked in the morning and decreasing towards evening, was confirmed by me.

This seems to me to be a case of acquired hemolytic jaundice. Two types of hemolytic jaundice are recognized, the congenital and the acquired. In the congenital type there is a definite history of cases in the immediate family, and the disease

may last for years, well into adult life. Usually there are recurring attacks of pain over the liver with fever and increase of the skin discoloration. As some one has remarked, this is more or less of an esthetic disease in the sense that it does not keep the patient from performing his usual activities, but he is always of a distinct yellow color. The cases often begin in infancy and may be so severe as to be fatal before the third year. Usually the discoloration is not noted particularly until the adolescent period. The other type usually begins later in life and the blood does not show the very marked fragility of the red cells which the red cells of patients of the congenital type show. Increased fragility of the red cells is an essential sign in the diagnosis of the congenital type.

The hemoglobinuria in this case must be occasioned by a very rapid auto-hemolysis which throws enormous quantities of hemoglobin into the blood stream. As this is a foreign substance it is then removed by the kidneys. This seems to be borne out by the fact that when these attacks occur the fall in red cells and hemoglobin is precipitous. No explanation is offered of the fact that the hemoglobinuria is so pronounced in the morning and scarcely appears in the evening urine. The fact that the patient is only nineteen years old, the red cells are not particularly changed in appearance, there are no macrocytes or microcytes. there are no mouth symptoms. would argue against pernicious anemia. The rather precipitant character of the anemia and the distinct jaundice rather than a sallow color, the lack of hemorrhages from the stomach, would seem to be against the diagnosis of Banti's disease. Although the platelets were not counted. a note was made that in the stained smear they were greatly decreased. The bleeding time was not prolonged and it was learned that the blood clotted well. It is considered that essential thrombocytopenia can be ruled out. Although in this case the fragility of the red cells is not strikingly increased. nevertheless it is at the upper limit of normal. There is the continuous jaundice which shows fluctuation: there is an enlarged spleen; it occurs in a young person; the indirect van den Bergh's test is positive; and there are definite attacks of rapid hemolysis in which both red cells and hemoglobin are reduced. These points appear to be sufficient to substantiate the diagnosis of hemolytic jaundice.

The treatment of such a case as this is splenectomy. Just what role the spleen has in this disease is not definitely known, but that it has something to do with the rapid destruction of the red cells seems quite probable from the fact that removal of the spleen cures both congenital and hemolytic types of jaundice. This has been advised in this particular case but as yet has not been carried through.

A NEW CASE REPORT

A married woman, age 51, came in complaining that her heart beat fast when she walked rapidly or when she went upstairs, and that it occasionally skipped a beat. She had had no swelling of the feet or unusual shortness of breath.

Her family history was quite unimportant. She lives in a small town and had always enjoyed very good health. Eighteen years ago she had the left breast removed. Whether this was a malignant tumor is doubtful. About the same time she had a laparotomy performed in which her tubes were cut and one ovary removed. For years she has been slightly constipated and has taken a great deal of medicine. Her normal weight for years was about 145 pounds. For the past six or seven years she has been showing less and less menstruation. During this period she had pain in the back of the neck going over to the shoulders with many vague symptoms and occasional hot flashes. One year ago menstruation ceased entirely and she has seen nothing since. In 1919 she had an attack of purulent bronchitis. For the last seven years she has gradually gained in weight from 145 to 175 pounds, which is her present weight. Her appetite has been good. She has had no urinary disturbances.

A few weeks before she was seen she became conscious that her heart jumped in her body. She consulted a physician who found an occasional premature beat and the blood pressure elevated. She was told that she had high blood pressure and that her heart was skipping beats. He advised complete rest. This frightened her so that she practically gave up all her housework and began to treat herself as an invalid. She came to be examined to find out if her condition was serious.

On examination she was an exceedingly well nourished woman, 5 feet, 8 inches tall, eyes were clear and bright, pupils were normal, there were no eye signs present. There was no tremor. The neck was rather full but it was evidently due to

fat. No thyroid tissue was palpable. The chest was broad and well shaped. The lungs were clear. The left mammary gland had been removed. The heart apex was in the fifth interspace, 11 cm. from the midsternal line. There were no murmurs. There were no premature heart beats. The aortic second sound was not particularly accented. The radial arteries were not sclerosed. The blood pressure was 150/84. The pulse rate was 92 to the minute, regular. There was nothing found in the abdomen. The knee jerks were quite active. The urine was amber color, 1012 specific gravity no albumin, no sugar, acid in reaction.

Viewed with the fluoroscope the heart was of normal shape and an orthodiagraphic tracing showed the transverse diameter to be 11.1 cm., a a normal figure for her build.

Insulin and Glucose in Non-Diabetic Acidosis

BY WILLIAM THALHIMER, M.D.

Columbia Hospital

Milwaukee

The success of glucose-insulin administration in diabetic acidosis raised the question as to whether or not other types of acidosis might respond equally as well to this treatment. This was found to be the case in pernicious vomiting of pregnancy and in postoperative acidosis. In treating these acidoses, not only must insulin be given to speed up the carbohydrate metabolism but carbohydrate itself must be given to prevent the dangers of hypoglycemia as a result of the insulin action. The best way to administer this carbohydrate is in the form of a glucose solution. The glucose and insulin may be administered together intravenously in emergency conditions, or the glucose may be administered in fruit juices by mouth and the insulin given subcutaneously.

There are some interesting facts brought out as a result of glucose and insulin administration in non-diabetic acidosis. In the first place, sugar will appear in the urine for 12 to 18 hours after the administration. In normal individuals, if one makes a continuous slow injection of glucose, it will be found that the blood sugar curve will fall even though glucose is still being injected, and within 45 minutes after the cessation of the injection, the blood sugar will fall to a level of 40 to 50 milligrams per cent, and the individual will show the typical symptoms of insulin shock. If insulin is administered along with the glucose, the period of hypoglycemia will not be hastened, and the blood sugar will fall to the same level but not any lower. Apparently the administration of glucose to a normal individual stimulates insulin secretion to such an extent that the glucose is removed rapidly from the blood and is probably stored, even though the glucose is being continuously administered. Secondly, there is evidence of an interrelation between the glands of internal secretion with regard to the blood sugar level. Thyroid feeding will increase blood sugar. One of the important actions of insulin is to facilitate glucose storage. It is this factor which is helpful in alleviating the pernicious vomiting of pregnancy; in other words, insulin tends to prevent the complication of starvation. The intravenous injection of glucose before operation in order to place the patient in a better physiological condition for the operation, has been found to be of no value when there is no evidence of starvation in the patient. The increased amount of glucose causes hypoglycemia, and has been found actually to be depressing. It is better apparently to let a patient eat what sweet stuff he will before an operation and to encourage the eating of fruits. Glucose should be given intravenously only in conditions of starvation or of ketosis.

At the laboratories of the Columbia Hospital efforts have been made to find a method for the quantitative determination of insulin in blood. These have not been successful. It has been found, however, that insulin added to blood in vitro cannot be recovered by the usual processes for extracting insulin.

SUMMARY

Carbohydrate metabolism is not a general function of the cells of the body but depends upon the internal secretion of insulin. The secretion of insulin depends, in turn, upon the demands and needs of the body for it.

DISCUSSION

Dr. Thalhimer's paper, which was illustrated by some interesting lantern slides, was discussed by Dr. E. L. Sevringhaus and Dr. H. V. Gibson.

December 7, 1926.

Diverticulites of Illeum; Acute Perforative

BY C. REINECK, M.D.
Appleton

I report the following case, first, because it is extremely rare, and secondly, because it offers great difficulty of pre-operative diagnosis.

The following is a brief history of the case: Child, 4 years, male, taken with cramps in abdomen on Oct. 14th. No vomiting and pains subsided some towards evening. Ate very little that day and slept fairly well during the night. Bowels moved twice. On Oct. 15th pains again became more severe, so that child cried. The pains were colicky in character. Child brought to office at 5 P. M. Did not seem very ill. Temp. 99.8, pulse 110. Tenderness and rigidity over abdomen, slightly more so on right side. No vomiting. Child sent to St. Elizabeth's Hospital. History also revealed that the child had similar attacks on several occasions last month. Laboratory findings as follows: Urine—no alb., no sugar, acid in reaction, indican ++++, acetone +++; blood findings: leucocytosis, 12,000, S.L. 21 per cent, L.L. 3 per cent, P.N. 74 per cent, eosinophiles, 1 per cent, basophiles, 1 per cent.

At 9 P. M., temp. 99.6, pulse 120, resp. 24. Slept all night without any anodyne. At 7 A. M. following morning the blood count was 22,000 whites, temp. 99.6, pulse 120, resp. 26. Child did not appear very ill but operation was deemed best and consent for same was finally obtained from parents.

Although the history and findings were not very typical of appendicitis, that was the most probable diagnosis, so acute appendicitis was put down as the pre-operative diagnosis.

Operation: Under general ether anesthesia the abdomen was opened in the appendiceal region, appendix delivered and amputated in the usual manner. While highly congested externally, internally it was not and did not seem sufficient to cause all the symptoms.

Through a rather small incision further examination of contents of abdomen was made and a lump was felt towards the median line and was delivered and found to be a bunch of omentum adhered to and around a loop of small bowel. Adhesion was very friable and found to be a fresh exudate, gangrenous in character, and revealed underneath a perforated diverticulum at about the mid third of ileum.

The size of the diverticulum was about three-fourths of an inch wide and three-fourths of an inch long and perforation size of small pea at the extreme tip. Fortunately the omentum had protected the abdominal cavity from being infected. The entire distal portion of the diverticulum was gangrenous.

The diverticulum was amputated and bowel sewed over, not inverted like stump of an appendix as that would have narrowed the lumen too much. Abdomen closed in the usual manner and a soft rubber drain was left in for 48 hours. No drainage followed and outside of an extreme restlessness, due to the acidosis, the patient made an uneventful recovery, and left the hospital in ten days.

This case should teach us to look for further cause for the symptoms if they are out of proportion to the pathology so far found.

Mesenteric Thrombosis, With Symptoms of Obstruction; Case Report

BY GUY W. CARLSON, M.D., AND CARL D. NEIDHOLD, M.D.
Appleton

Thrombosis of the mesenteric artery, while not rare, is not usually recognized until the time of operation or postmortem. The diagnosis is extremely difficult, and the acute cases are usually regarded as obstruction. The difficulty with which an accurate diagnosis is made, the danger attending a delayed operation, and the fact that all these cases are operative, are sufficient reasons to report a case of thrombosis of the mesenteric vessels.

History: L. D., male, retired farmer, age 58, admitted to the service of Dr. W. N. Moore, St. Elizabeth's Hospital on January 13, 1925, at 9:30 P. M. The family history was unimportant. The previous personal history except for numerous attacks of so-called "intestinal indigestion" the patient had always enjoyed good health. These attacks had recurred at various intervals during the past several years and were thought to be attacks of heart disease.

On January 13, the patient began complaining of sudden cramp-like pain in his abdomen localized about the umbilicus. Vomiting occurred and was persistent. Following an enema the patient passed a soft stool but no blood was present. The temperature was 98.8 degrees F., the pulse rapid, the same cramp-like pain continued, and the vomiting was incessant. The urine examination showed a trace of albumen, a few white cells and red cells. The white blood count was 10,300. The blood pressure reading was systolic 162 and the diastolic reading 86.

There was board-like rigidity of the abdominal muscles. No masses palpable, slight distention, tenderness general but greatest to the right and around the umbilicus.

Diagnosis: Acute appendicitis. General peritonitis.

Operation: January 13, 1925. A suprapubic incision was made. Few adhesions were found. There was a large amount of a free bloody serous fluid in the abdomen. The ileum from a point of about twelve inches from the caecum extending upwards for five feet was distended with a "V" shaped mesentery, all of a

purple and black color. No evidence of an obstruction was present. The line of demarcation was sharp and definite. The coils of gangrenous intestine were brought up out of the wound, clamped and five feet of the small intestine with "V" section of mesentery removed. An end-to-end anastomosis was done. The mesentery was ligated with suture ligatures. The wound was closed without drainage.

The patient reacted well from the shock but died at the end of the fourth day. He exhibited the symptoms of an acute ileus.

Postmortem: One hour after death an autopsy was held. The anatomic diagnosis was: Paralytic ileus; chronic fibrous myocarditis; chronic diffuse nephritis; recent infarcts of kidney cortex; chronic fibrous atrophic appendicitis; thrombosis with occlusion of the superior mesenteric artery; necrosis and gangrene of small intestine; copper reducing substance in the urine—diabetes mellitis?

CONCLUSIONS

In the majority of instances the clinical symptoms are suggestive of acute peritonitis, acute appendicitis, or acute intestinal obstruction.

When the mesenteric veins are occluded, it is always due to thrombosis. Either embolism or thrombosis may cause occlusion of the mesenteric arteries. At necropsy, however, it is difficult to differentiate between thrombosis and embolism of the mesenteric arteries.

As causes of venous thrombosis all factors causing stasis of the portal system are of importance. Endocarditis, arteriosclerosis and any condition leading to the formation of thrombi may be the cause for the mesenteric vascular occlusion.

An early diagnosis should be reached when the symptoms and signs are associated with heart disease to account for embolism of the arteries, especially malignant endocarditis, mitral stenosis and an auricular fibrillation.

In the presence of sudden acute symptoms which include intense abdominal pain, collapse and rigidity of the abdominal wall, very little time should be lost in speculation as to the cause of the lesion.

Salivary Calculi

BY E. A. WALDECK, M.D.
Milwaukee

Salivary concretions most frequently form in Wharton's duct. In most cases the stones are formed in a chronically infected gland. The following case is quite typical.

A man, aged 55 years, consulted us on September 15, 1926, with the complaint of a painful swelling below the angle of the right jaw for the past month. The pain and swelling were aggravated by eating.

In August, 1918, the patient remembers having had a similar complaint except that the pain was similar to that of a toothache and the abscess broke and suppurated into the mouth. At this time several small concretions escaped with the pus and two larger stones were removed by a physician who incised the fistulous opening of the right submaxillary duct. Since then at indefinite intervals small concretions could be expressed from this fistulous opening.

Examination at the present time showed a marked swelling of the right submaxillary gland which was painful on pressure. The teeth were in

excellent condition and there was no inflammation of the orifices of the submaxillary ducts. At the level of the last molar tooth, beneath the tongue on the right side was a small painful raised area which on probing proved to be the fistulous opening of the right submaxillary duct. A stone-like substance was felt in the duct and by enlarging the fistulous opening a smooth, oval-shaped stone weighing 30 grains and one inch long was removed by means of hooks. The accompanying photograph shows the actual size of the stone.

COMMENT

Of the cases reported in literature* the larger sized stones usually lodge in the posterior part of Wharton's duct. The peculiar anatomical formation of the submaxillary duct which is much larger in caliber than its orifice probably explains the case by which infection can take place in this duct.

*Erdman: Journal American Medical Association, May 22, 1923.

Puncture Wounds; a Point in Their Care

BY WILLIAM FLETCHER, M.D.
Salem

In speaking of puncture wounds I refer particularly to wounds made by stepping on nails. I was taught to enlarge the wound so as to thoroughly cleanse and swab it out with iodine or any good antiseptic, strong enough for sterilization. To do this causes the patient much pain. Many refuse to have it done. Then some of them suffer from the scar which forms. In some patients callouses form and give trouble for years.

Because of the difficulty in enlarging and making the wound sterile, I have found that in many cases doctors just dress the wound and let it go, trusting to luck that nothing happens. Others give a dose of tetanus serum and feel safe.

For the past six or eight years I have been using another method which has given good results. It is, of course, more successful if done soon after the injury. In neglected wounds where changes have taken place and much swelling has occurred, it is best to open the wound and clean it surgically.

My method is to use a lachrymal syringe as it has a blunt point; or if the wound is too deep, I use a silver uterine applicator. With the blunt pointed needle I explore the wound to its depth. Then I inject into the wound a two per cent of 220 mercurochrome and put it in under some pressure as I wish to make sure it reaches all parts of the wound. This gives little pain and is, I believe, as effective as iodine. Results have been all one could desire. I always give an immunizing dose of antitetanic serum.

For ease of application and agreeableness to the patient it is satisfactory.

Abstract of Papers Before University of Wisconsin Medical Society

C. D. LEAKE, EDITOR

THE HUMORAL TRANSMISSION OF NERVOUS IMPULSES

BY PROF. HENRI FREDERICQUE
University of Liege
Belgium

The organs of the body cannot function independently of each other but it is necessary that they cooperate and work in harmony. The regulating mechanisms controlling this cooperation of the various functions of the body are much more complicated than was formerly thought. Twenty-five years ago the only regulating mechanism known was the central nervous system, and nervous reflexes were thought to regulate all physiological activity. The discovery of secretin by Bayliss and Starling in 1902 drew attention to other possible mechanisms. This discovery showed that at least two distinct mechanisms existed: (1) nervous reflex and (2) a humoral control by means of the glands of internal secretion.

The question arises, are these two mechanisms really distinct? In 1921 Loewie demonstrated a relationship between these two mechanisms by revealing the possibility of a humoral transmission of nervous impulses to the heart. A frog's heart was isolated, except for vagal connections, and was perfused with Ringer's solution. The vagus nerve was then stimulated and, while the heart was slowed, the perfusate was collected. This perfusate, perfused through a normal heart in another frog, slowed the second heart. The same thing was demonstrated in crossed circulation experiments in turtles, in rabbits, and in dogs. Loewie also showed that accelerator impulses obtained by stimulating the sympathetic nerves to the heart may be similarly transmitted through the blood.

The excitability of living tissue may be measured in two ways: (1) by the old-fashioned threshold method and (2) by the quickness of excitability, or the chronaxia. In regard to the heart, stimulation of the vagus shortens the chronaxia, whereas stimulation of the accelerator fibers lengthens the chronaxia. In crossed circulation experiments in dogs, stimulation of the vagus nerve in one dog results in a shortening of the chronaxia of the heart of the second dog, which receives the arterial blood from the first. In the same way it was found that stimulation of the accelerators in the first dog lengthened the chronaxia of the heart in the second dog.

The effect has been shown to apply to other organs. For example, if the vagus in a frog is stimulated, the perfusate collected during this

period of stimulation will cause the stomach of a normal frog to contract. On the other hand, Brinkman and Miss Van Dan also showed that, if the accelerators to the heart are stimulated, the cardiac perfusate causes an inhibition of gastric contraction. Again, Zungz and Govaerts in 1924, showed in crossed circulation experiments in dogs, that a stimulation of the vagus in the first dog is followed by a fall in blood pressure in the second dog.

From these experiments it is felt that the excitation of a nerve liberates, at the tissue in which the nerve ends, certain chemical substances which will give the same effect as the stimulation of the nerve itself. What type of chemical substances may this be? In 1905 Howell and Duke showed that potassium is increased during vagal stimulation, and that calcium is increased during sympathetic stimulation. The antagonism of these ions is well known with regard to the heart, semi-permeable membranes, and oil and water suspensions, gut atropin is not antagonistic to potassium but it is antagonistic to vagal stimulation. It has also been found that vagal stimulation increases the choline concentration of the blood. Now atropin does antagonize choline. Certain properties of the vagal active substance are known. It is destroyed by heat and alkali; it is soluble in alcohol; can be dried and is dialyzable; it is not species specific but more like a real hormone.

What are the factors of the neuro-humoral mechanism? It remains for the future to determine whether nerves act on organs by means of the production of chemical agents at their terminations, or whether nerves act directly upon the organs with these chemical substances accidentally produced in the response. Of course the similar embryonic origin of the sympathetic nervous system and of the chromaffin tissue of the adrenal medulla is interesting in this connection. It has long been known that stimulation of the splanchnic nerves will liberate adrenalin.

CONCLUSION

The interesting discovery that nervous activity liberates chemical agents which have the same effect on normal tissue as the nervous stimulation itself, has shown the possibility of humoral transmission of nervous impulses. This bridges the gap between the two types of the harmonic functioning of the organs of the body: (a) by nerves, (b) by hormones.

DISCUSSION

This very interesting paper of Professor Frederieque was discussed by Dr. J. A. E. Eyster, who spoke of Howell and Duke's experiments. It was found that the location of the pacemaker in the heart was changed both by vagal stimulation and by potassium.

January 18, 1927.

THE INFLUENCE OF THE VARIOUS KETONE BODIES ON THE ACTION OF INSULIN

BY E. L. SEVRINGHAUS, M.D.

Department of Physiological Chemistry, University of Wisconsin

In 1924 Miss Margaret Smith, a graduate student, became interested in a suggestion made by Dr. A. J. Carlson, Professor of Physiology at the University of Chicago, regarding the effect of the type of diet and the time of eating on blood sugar. Preliminary studies of the sugar concentration in the blood, taken shortly after a moderate breakfast, showed abnormally high values in fasting subjects. These same subjects placed upon regular diet showed no such high values. Evidence was thus furnished that fasting diminished the ability of the body to oxidize sugar.

The problem was carried on by Mrs. Brindley, another graduate student, who studied the effect of varying the length of fasting on the blood sugar tolerance. It was found that the abnormally high values appeared usually only after the fast had gone beyond 24 hours. It was also noted that acetone bodies appeared in the urine following prolonged fasting. The appearance of acetone in the urine is known to be due to incomplete fat oxidation and indicates that the fat reserves of the body are being drawn upon following the depletion of the carbohydrate stores. More careful study indicated that there is no loss of tolerance for sugar until this ketosis occurs. These findings suggested the determination of whether the loss of tolerance to sugar is due to the ketosis or to the inhibiting effect of one of the ketone bodies. Accordingly, studies were made of the effects of injecting the various ketone bodies into experimental animals.

Since acetone itself is the most easily prepared in pure form, the initial studies were made with this substance. Experiments performed by Miss Groth, in which sub-toxic doses of acetone were injected into rabbits, indicated that there was no effect from this substance on the blood sugar curve

when samples were drawn at hourly intervals for five or six hours after the injection. Acetone injected along with insulin gave a resulting blood sugar curve not significantly different from that noted when insulin is injected alone.

Studies with aceto-acetic acid were made by Miss Woolverton and Miss Whipple, also graduate students. In the case of this substance it was found that there was a decreased tolerance to sugar after its injection. Furthermore, it was noted that the injection of aceto-acetic acid along with insulin tended to delay the action of the insulin, and that this delaying effect was related to the dosage of centration of sugar in the blood after a meal or after the injection of glucose. The very significant discovery was made that insulin treated with aceto-aceto-acetic acid injected, the greater was the con- the aceto-acetic acid. The greater the amount of acetic acid in vitro lost its activity. Control experiments with sodium chloride showed that there was apparently some chemical reaction between the aceto-acetic acid and insulin. This important finding may give a valuable clue to the chemical nature of insulin since it can be demonstrated in the test tube.

Beta-hydroxy-butyric acid is optically active in the form in which it occurs in the human body. The synthetic material is racemic. Experiments conducted by Sister Tarsilla Mock with the synthetic material showed that this does not interfere at all with the action of insulin.

To summarize these experiments, then, it has been found that the products of abnormal fat oxidation, viz., ketone bodies (especially aceto-acetic acid), interfere with the oxidation of carbohydrates and interfere with the activity of insulin in carbohydrate metabolism. Fat oxidation, however, is only deranged when the carbohydrate metabolism itself is thrown out of order. Thus, a vicious cycle is set up which renders the condition of the patient increasingly precarious. It has long been known clinically that larger doses of insulin are necessary to control diabetes when the patient is excreting acetone bodies than when no ketosis is present. It may be that these experiments give the explanation to this clinical fact. These studies are also significant in the pernicious vomiting of pregnancy and post-operative nausea. In both these conditions, the short periods of starvation and the resultant necessity of the body to draw upon the fat stores initiate the vicious cycle, above described. It is of extreme clinical importance that the sugar reserves of the body be maintained whenever a person is ill. In some individuals the sugar reserves may be exhausted in 12 to 18 hours after the withholding of food. If a patient cannot take food by mouth, glucose should be administered by rectum or parenterally.

SUMMARY

A careful study of the effects of the various ketone bodies upon the action of insulin shows that acetone and beta-hydroxy-butyric acid have practically no effect upon the activity of insulin nor upon the tolerance of an individual for sugar. Aceto-acetic acid, however, tends to interfere with the activity of insulin, as may be shown in vitro, and also tends to reduce the tolerance of a person for sugar. These findings indicate the necessity of maintaining a sugar reserve in the body so that ketosis and a vicious cycle will not result.

COMMITTEES APPOINTED

Members of the program and arrangement committees for the 86th Annual Meeting of the State Medical Society of Wisconsin, to be held at Eau Claire, September 20th to 22nd, inclusive, have been announced by President Arthur W. Rogers. Dr. H. M. Stang, councilor for the tenth district, will head the committee on scientific program and Dr. R. E. Mitchell, former councilor, will act as chairman of the committee on all arrangements.

Members of the two committees are: Committee on Scientific Program: Drs. H. M. Stang, Eau Claire, Chairman; Nels Werner, Eau Claire; C. B. Hatleberg, Chippewa Falls; R. C. Blankinship, Madison; B. B. Rowley, Milwaukee, and F. G. Gaenslen, Milwaukee. Committee on Arrangements: Drs. R. E. Mitchell, Eau Claire, Chairman; E. E. Tupper, G. J. Hoyme, J. C. Baird, E. P. Hayes, G. E. Curtis, and G. W. Beebe, all of Eau Claire.

ADDRESSES OMITTED

In the March issue of the Wisconsin Medical Journal an omission occurred in that the Journal did not include the addresses of the Milwaukee and Minnesota branches of the Victor X-Ray Corporation in their regular advertisement. These branches are: Milwaukee: 153 East Wells Street, and Minneapolis: 550-4 Baker Arcade Building, 733 Marquette Avenue.

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SERVICE AVAILABLE

There is listed the following definite services that are available to our readers—the members of the State Medical Society of Wisconsin. If you have a need not covered here address the Secretary, Mr. J. G. Crownhart, 153 E. Wells Street, Milwaukee. "Let George do it."

FOR THE MEMBER

1. *Package Libraries* are now available on Cancer, Schick Test, Vaccination, Periodical Physical Examinations, Insulin, Fractures of Long Bone, Protein Treatment, Control of Communicable Diseases, Goiter, Digitalis, Pneumonia, Diseases of the Knee, Encephalitis, Asthma, Epilepsy, Meningitis and Scarlet Fever. Address Package Library Department, Extension Division, University of Wisconsin, Madison. Material on other subjects compiled upon request.

2. *Medical* Books will be loaned by the Medical Library, University of Wisconsin, Madison, Mr. Walter Smith, Librarian. Order through local library where possible.

3. *Physicians' Exchange Column* is open to all members without charge.

4. *New Scientific Publications* listed in the Book Review columns of this Journal are available for inspection by the members. They are in the Medical Library, University of Wisconsin, Madison. Place your order through your local library where possible or address Mr. Walter Smith, Librarian.

5. *State Laws* and departmental rulings can be secured through the Secretary's office.

6. *Legal Advice* upon questions pertaining to the practice of medicine will be given in so far as is possible. A complete statement of the question or facts must be forwarded.

7. *Inquiries.* Any inquiry with reference to pharmaceuticals, surgical instruments or any other manufactured product which you may need in home, office, sanitarium or hospital, will be promptly answered. Address all inquiries to Wisconsin Medical Journal, or write direct to Cooperative Medical Advertising Bureau, 535 North Dearborn Street, Chicago, Illinois. The Bureau is equipped with catalogues and price lists and can supply information by return mail.

FOR THE COUNTY SOCIETY

1. *Program Material.* Pursuant to authorization by the 1924 House of Delegates the Secretary is arranging to make program material available without cost. The following can now be secured:

A. Departmental Officers of the State Board of Health. Address Dr. C. A. Harper, State Health Officer, State Capitol, Madison, Wis.

B. Clinicians of the Wisconsin Anti-Tuberculosis Association when in vicinity. Address Clinic Dept., W. A. T. A., 558 Jefferson Street, Milwaukee.

C. Councilors and Officers of the State Society. Address the individual.

2. *Annual Statements.* Uniform annual statements can be had without cost. Address the Secretary, advising number desired.

EDITORIALS

RESPONSIBILITY IN THE TREATMENT OF FRACTURES

THE fact that a very large number of the suits for malpractice brought against physicians are based upon alleged bad results in the treatment of fractures seems to indicate that the public, the courts and industrial boards now expect and demand more accurate reposition of the fragments of fractured bones than formerly. Familiarity with the appearance of these fractures as shown by the x-ray has given the laity an all too critical idea of the necessity of accuracy in reposition and alignment of fracture surfaces. Generally speaking, one may fairly say that there is a close relation between anatomical replacement and functional results. The more nearly the replacement of fragments approaches the normal condition the better the chance for complete recovery of function, other conditions being equal. We are all aware, on the other hand, that the x-ray appearance of a fracture does not necessarily determine the prognosis as to the final functional result. This latter fact is one that the medical profession should seek to impress more generally upon the public.

Until the public comes to realize that the x-ray plate is only one factor to be used in estimating the final functional result, it behooves the physician who undertakes the treatment of fractures to protect himself in such treatment as he may institute by having x-ray pictures *taken in two directions at right angles to each other* not only before the treatment is begun but during the course of treatment and at the end as a matter of record as to the final result at the time the patient is discharged. The patient or those responsible for his care should be shown the x-ray plates and be made to share the responsibility for the final result by agreement or disagreement with the procedures being carried out in the treatment at the time they are being employed. It is only in this way that the surgeon can protect himself from false impressions as to bad results which so often arise in the minds of a hypercritical public.—J. F. S.

AFTER THOUGHTS

THE highly regrettable and tragic accident in a Chicago hospital which resulted in the death recently of six babies, presumably as a result of having boric acid solution administered internally instead of distilled water, has, of course, occasioned headlines in the daily press and much excitement.

Those of us who are acquainted with human fallability are inclined more to pity than to blame the unfortunate nurses who apparently made the errors. However, there will be many who will not see in this incident an illuminating comparison between our reactions to what is sensational and what is comparatively commonplace.

It is probably not unusual in the city of Chicago for six babies, a week old or less, to die in one day. In proportion to their smaller populations, cities and even rural areas are having corresponding numbers of deaths from causes peculiar to early infancy with such consistency that these have ceased to provoke comment except from close observers of infant mortality. It is the spectacular aspect of these Chicago deaths which made the wide public appeal and not, unfortunately, the actual loss of these six babies.

Hospitals and others who administer or dispense medicines, including physicians, should be spurred by this occurrence to renewed insistence that all preparations must at all times be plainly and unmistakably labeled. The use of bottles of distinctive size, shape, color or even texture for preparations not to be used internally should become a fixed practice and should extend to the home medicine chest.

Above all more attention should be paid to the preventable infant deaths which are occurring in all communities all the time and which are just as important, though of lesser *news value*, than the multiple tragedy recently enacted in Chicago.

—W. W. B.

THE LABORATORY IN MEDICAL DIAGNOSIS

THE increasing number of commercial laboratories which purport to perform all kinds of tests on the various excretions, secretions, and tissues of the body has hindered rather than helped the diagnosis of disease. Further, the impression, if not conviction, in the minds of many doctors is that the laboratory can make the diagnosis so that there is a widespread feeling even in this day to accept the laboratory report at its face value although it often runs counter to the history

and clinical findings. This is an old story and yet it is important enough to discuss from time to time.

A fundamental principle can be at once laid down: Laboratory tests (including x-ray examinations) are only *aids* to diagnosis. All one receives from the laboratory is additional data which may or may not be determining in diagnosis. The tendency of the laboratory is to make the diagnosis from the specimen examined. There is real suffering or even danger to the patient entailed in such an attitude. Unfortunately too many doctors accept the laboratory report as the last word.

The situation might not be so serious if all the laboratories were headed by the most competent pathologists who realized the limitations of their field, and were manned by the most competent technicians who never reported on a test unless every condition in the performance of the test was absolutely properly fulfilled. This is certainly not the case. There are too many half-baked technicians in commercial laboratories and too many of the same kind in hospital laboratories. Better no laboratory at all than a so-called laboratory where there is only a technician and no doctor on the staff who has himself been through the laboratory training and appreciates the great limitations of the laboratory.

What can we expect though when we train our students of medicine in hospitals where the first question asked about a suspected case of nephritis is, "What is the blood urea?" Or about a case of heart disease with cyanosis, "What is the oxygen unsaturation of the venous and arterial blood?" Or about a case of rapid pulse and suspected thyrotoxicosis, "What is the basal metabolism?" etc. Students, hearing their instructors ask for the results of laboratory tests before the instructors have heard and digested the clinical history and physical examination, acquire an entirely false conception of the place of the laboratory in diagnosis.

Medical diagnosis can never be made a mathematical problem. Medicine is and always will be largely an art, the arguments of certain enthusiastic laboratory workers to the contrary notwithstanding. As no two people look absolutely alike exteriorly, so no two people are absolutely alike interiorly, nor are any two people apt to react absolutely alike to any given poison introduced into their bodies.

Recently the writer saw a report from a commercial laboratory upon the examination of a single specimen of urine. The report is too long to quote. Suffice it to say that not only was a definite diagnosis of intestinal "auto-intoxication" made but directions for treatment to combat the increase of phosphates, the increase of urobilin, the amphoteric reaction of the urine, laid out in detail. Nonsensical you will say. True, but such laboratories are furnishing hundreds of such reports daily to doctors.

Again, there is no test which is so subject to variations as the basal metabolism. Recently in a case strongly suggesting from the history and physical examination hypothyroidism, a basal metabolism in one nationally known clinic was —9. Several months later, the patient being under no treatment, a basal metabolism made by a competent laboratory was +25 and two weeks later, the patient in the meantime being under no treatment, the basal metabolism was +2.

With Chvostek in Austria, Peugnier in France, Fraser in England, Stengel and others in this country, the writer has felt for some years that the supposedly mathematical accuracy of the laboratory was superseding the more important but less spectacular methods of careful history taking, thorough physical examination followed by some brain work. No one has yet invented a substitute for brains. Laboratory methods have become the lazy man's short cut to diagnosis. This is truly an unfortunate state of affairs. It has also led, not infrequently, to serious mistakes which have ultimately harmed patients.

We plead for the intelligent and discriminating use of laboratory methods by the profession and the return to the more time-consuming but still more accurate study of the patient as a complex human organism subject to influences which no laboratory methods can ever solve.—L. M. W.

OTITIS MENINGITIS

This report by Wells P. Eagleton, Newark, N. J. (*Journal A. M. A.*, Nov. 6, 1926), is based on thirty-three consecutive cases of meningitis, with ten operative and one spontaneous recovery. Ten patients were not operated on because they were in a terminal stage when first seen. Thirteen postmortems were obtained from the twenty-two deaths. All cases presented the clinical picture of meningitis; and the condition found at operation warranted the diagnosis of septic meningitis, which if not surgically attacked would have ended fatally.

THE PRESIDENT'S PAGE

Arthur W. Rogers

REPORTS OF COUNTY SECRETARIES

It is interesting if not illuminating to observe the reports sent in to this journal by the secretaries of the various county medical societies.

During the past two years we have made it a point to read and study such reports as they have appeared in the medical journals of the states contiguous to our own, and from such examination we have reached certain conclusions, viz: In the first place we have no apologies to offer in comparing the reports in our journal with those of other states. There is one outstanding feature in these reports in all of these journals. Certain counties have a full and interesting report of each meeting of their society, while other counties have but an occasional report and that not complete nor especially interesting.

I take it that these reports but reflect the interest and activity of the individual secretary. If he is a live wire, he presents a good program with a resultant large attendance and such a meeting he is quite ready and proud to report. Of course, the reverse is likewise true.

It should be remembered that if you wish to put your county society on the map and keep it there, you must get into print each month. If you do this, you will feel the urge to produce something worth reporting other than a "fine feed."

Your reports but reflect the activity of your county unit, and are excellent evidence of proper organization.

In the final analysis, a prompt, full and interesting monthly report from each society works for the betterment of your state organization. The reports are a part of the responsibility of officers, and the obligation that you accept upon assuming office.

VALUE RECEIVED

On March 31st over 1600 members had forwarded their 1927 dues, establishing a new record for prompt payment. Some are still delinquent through oversight but I venture to say that our membership this year will be the largest in our history and will probably exceed 2,100.

One measure defeated last month would incidentally have cost practically every physician in the state $25 this year and $5 a year thereafter. I recite this, not as a major accomplishment, but only as an infinitesimal part of the program of service now rendered by our Society. Each year our Society gives more and more that cannot be calculated in dollars and cents. And as such service continues so will old records continue to fall by the wayside.

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SOCIETY PROCEEDINGS

CHIPPEWA

The Chippewa County Medical Society held its first meeting of the year at the Chippewa County Asylum. Mr. and Mrs. Charles Liche were the hosts. The necessity of a tuberculosis sanatorium in Chippewa County was discussed and the society recommended to the county board that an attempt should be made to establish a sanatorium in that vicinity in the very near future. Dr. E. L. Sevringhaus, Madison, presented a very practical paper on "What We Eat and Why." Dr. H. K. Tenney, also of Madison, spoke on "Infant Feeding and the Treatment of Vomiting in Children."

—W. C. H.

EAU CLAIRE AND ASSOCIATED

The Eau Claire and Associated Counties Medical Society have held three important meetings within the last few months. Twenty-six members were present on December 20th when all officers of the society were re-elected: President, Dr. G. W. Beebe; Vice-President, Dr. J. E. B. Ziegler; Secretary-Treasurer, Dr. H. M. Stang; Censor, Dr. A. L. Payne. Drs. Stang and Oscar Blosmo were re-elected as delegates to the state meeting with alternates Drs. B. F. Johnson, Mondovi, and F. E. Butler, Menomonie. A very enjoyable social evening was spent.

The January meeting was held at the Eau Claire Hotel and there were thirty-nine present. Dr. Arthur W. Rogers, president, and George Crownhart, secretary of the State Society, were guests. Dr. Rogers gave a very interesting talk on the plans for the state meeting and followed this with a paper on "The Relation of Psychiatry to the General Practitioner." Mr. Crownhart added a few remarks on the tentative plans for the state meeting, which will be held in Eau Claire in September.

The February meeting was held at the Eau Claire Hotel on the 28th. There were thirty-one members present and a very interesting program was given. Dr. Hans Reese of the University of Wisconsin spoke on "The Use of Iodized Oil in the Diagnosis of Spinal Cord Tumors" and Dr. Alton B. Ochsner, assistant professor of surgery, University of Wisconsin, on "The Use of Iodized Oil in the Treatment of Bronchial Diseases." Dr. Ochsner also gave a very interesting clinic in the morning at both Eau Claire hospitals, the Sacred Heart and the Luther, demonstrating the technique of placing the lipiodol in the bronchial tree.—H. M. S.

KENOSHA

At a meeting of the Kenosha County Medical Society on Tuesday evening, March 8th, Dr. Clifford Grulee, chief of staff of the Presbyterian Hospital, Chicago, spoke to the members on "Lobar Pneumonia in Infants and Young Children." It was a most excellent and instructive talk. The Racine County Medical Society were invited and many of the members attended this meeting.

The regular monthly meeting of the society was held on March 25th at which Dr. Paul O'Leary, chief of the section of dermatology and syphilology of the Mayo Clinic, gave an instructive talk on "Significance of the Itching Skin."—H. A. B.

JEFFERSON

On Thursday, March 24th, the first regular meeting of the Jefferson County Medical Society was held at the Cottage Hotel at Lake Mills. A dinner was served at six after which the business meeting and program followed. Papers were read by two Madison physicians, Dr. J. S. Evans and Dr. J. E. Gonce. Dr. Evans spoke on "Jaundice" and the subject of the paper by Dr. Gonce was "Infant Feeding."—A. C. N.

LA CROSSE

The members of the La Crosse County Medical Society met in monthly session on February 9th at the supervisor's room at the Court House. An interesting talk was given by Dr. C. A. Harper on "Status of Immunization in Scarlet Fever and Diphtheria."

At the March meeting of the society Dr. E. Evans spoke on his recent clinical tour and Dr. J. E. McLoone presented a paper on "Stomach and Bowel." A general discussion followed.—N. P. A.

MARATHON

The March meeting of the Marathon County Medical Society was held at the Wausau Memorial Hospital on the evening of the 2nd. For the program the members of the staff of the hospital conducted a clinic, presenting a number of interesting cases which were later discussed.—V. E. E.

OUTAGAMIE

The regular meeting of the Outagamie County Medical Society was held on Thursday evening, February 24th, at the Hotel Northern, Appleton. Dr. M. G. Peterman of the Milwaukee Children's Hospital read a very interesting paper on "Infant Feeding," and Dr. Stanley J. Seeger, also of Milwaukee, presented an instructive discussion on "Appendicitis in Children." Dr. Peterman held a pediatric clinic at St. Elizabeth's Hospital from 3:00 to 5:00 in the afternoon.

At the March meeting of the society, held on the 24th, Dr. Edward A. Oliver, Chicago, conducted a clinic on skin diseases and spoke on the same subject in the evening. The clinic was held at St. Elizabeth's Hospital and a dinner at Hotel Northern preceded Dr. Oliver's address.—C. D. N.

MILWAUKEE ACADEMY

At the meeting on March 8th of the Milwaukee Academy of Medicine, Dr. L. D. Smith presented a paper on "Some Disabilities About the Shoulder Joint;" Dr. S. J. Seeger spoke on "The Treatment of Burns with Special Reference to the Use of Tannic Acid," illustrated with lantern slides; Miss Taylor from the Brigham Hospital, Boston, gave a short talk on "Occupational Therapy in Chronic Joint Disease" with lantern slides, and Dr. M. G. Peterman addressed the members on "The Ketogenic Diet in Epilepsy."

The members of the Academy met again on March

22nd at which time Dr. Carl Henry Davis, Milwaukee, and Dr. E. L. Cornell, Chicago, presented papers. Dr. Davis spoke on "Changes in the Thyroid Function in Pregnancy" and Dr. Cornell's subject was "Hyperemesis Gravidarum."

Gifts of books and periodicals have been received from Drs. Howard Curl, Edwin Henes, D. E. W. Wenstrand, B. Schlomovitz, Wm. James Carson, H. C. Schumm, the State Medical Society and the Wisconsin Anti-Tuberculosis Association.—D. E. W. W.

ROCK

Dr. Charles A. Elliott, professor of internal medicine at Northwestern University Medical School, Chicago, spoke on "Periodical Health Examinations," with demonstration, at a meeting of the Rock County Medical Society, Thursday evening, February 24th, at Beloit. Dr. Vincent Koch, Janesville, read a paper on "Acute Pancreatitis."

A dinner preceded the program, together with a short entertainment under the direction of Dr. C. F. N. Schram. The meeting was very well attended.—H. E. K.

WISCONSIN UROLOGICAL SOCIETY

The Wisconsin Urological Society held a meeting at Milwaukee on Saturday, March 19th, at which the following program was presented: From 9:00 to 11:00 Dry Clinics at St. Joseph's Hospital conducted by Drs. A. J. Hood, W. M. Kearns and R. E. Stockinger; the physicians met at the Medical Arts Building in the afternoon and Dr. William J. Carson, first speaker on the program, spoke on "Metastatic Carcinoma in the Ureter"; Dr. Edward L. Miloslavich on "Pathology of Hypernephroma"; Dr. A. G. Jenner on "Bipolar Diathermic Treatment of Bladder Papilloma," and Dr. James C. Sargent on "Limitations of the Plain Radiogram in Urologic Diagnosis."

A dinner meeting was held at the Hotel Pfister at which time Dr. Hugh Cabot, of Ann Arbor, Michigan, addressed the physicians. His subject was "The Pathology and Pathogenesis of Non-Tuberculous Infections of the Kidney."—J. C. S.

UNIVERSITY OF WISCONSIN

"Carbon Dioxide Filtration in Anesthesia" was the subject of a talk by Dr. Ralph M. Waters, newly appointed professor of surgery in charge of anesthesia, at the regular meeting of the University of Wisconsin Medical Society on March 15th. On the same program was Dr. C. D. Leake who spoke on "Historical Development of Medical Ethics V. The Oath of Hippocrates" and Dr. Joseph F. Smith, Wausau, "Some Points in the Treatment of Fractures." This is the third of a series of addresses to be given by members of the preceptorial staff of the medical school.—C. D. L.

MILWAUKEE OTO-OPHTHALMIC

The March meeting of the Milwaukee Oto-Ophthalmic Society was held on the 15th at the University Club. Dr. Edward C. Nowak, New Hampton, Iowa, was the speaker of the evening on the subject of "Ocular Tuberculosis." Dr. Novak devotes his time to ophthalmology exclusively and was for five years an assistant in the Meller Clinic, Vienna.—E. R. R.

NEWS ITEMS AND PERSONALS

The fourth meeting of the physicians of the Beloit Clinic was held at Beloit Hospital on March 11th. Dr. J. Clyde Smith read a paper on "The Use of the Ophthalmoscope and the Significance of Retinal Pictures in Systemic Disease." This was followed by open discussion.

For five years the State Board of Health has sent out its traveling health car called the Child Welfare Special. From April to November this mobile unit since 1922 has visited rural communities remote from cities and hospitals. During the past five years the special has traveled about 30,000 miles, visiting 70 counties of the state and examining 23,579 children. Most of the children were infants or of pre-school age, and more than three-fourths were found to have preventable or remediable defects. The doctor and nurse of the special gave no medical treatment but provided the parents with records of the physical difficulties of their children, and suggested that they be taken to the family doctor or be given hospital treatment if necessary. Consideration is now being given to plans for sending the car out this spring upon its sixth season.

Dr. I. D. Wiltrout of Chippewa Falls has been appointed deputy state health officer for one year for the district centering at Eau Claire. Dr. V. A. Gudex of the Eau Claire district will move to Oshkosh and take charge of the district over which Dr. H. B. Sears, deceased, was deputy.

Dr. C. R. Bardeen, dean of the University of Wisconsin Medical School, was a recent visitor to the new Marshfield Clinic, where he inspected the course of study of three University of Wisconsin medical students who are doing work at the clinic. He was accompanied by Dr. Willard C. Rappleye, Yale University, New Haven, Conn., Director of the Commission on Medical Education, which is making a survey throughout the United States.

Dr. J. W. Prentice, who has practiced a number of years at Deer Park is now at Amery, where he has reopened the office formerly occupied by Dr. N. V. Sandin.

Dr. E. V. Brumbaugh, deputy health officer of Milwaukee, addressed the Women's Club of the Wisconsin University Settlement Association during February. His subject was "Newer Methods in the Prevention of Communicable Diseases."

Dr. F. S. Tuffley, Boscobel, disposed of his practice and all of his interest in Parker Hospital to Drs. E. H. Spiegelberg, C. S. Hayman and J. C. Betz in a recent transaction. The new owners have already redecorated and remodeled the premises and have about twenty-five bed capacity.

An expenditure of $1,200 annually for a period of ten or fifteen years on goiter prevention work, would wipe out that disease entirely in Winnebago county, Dr. V. A.

Gudex, state district deputy health officer, told the members of the county board during a March session. After stating that this section is located in the so-called goiter belt and therefore has a high percentage of that disorder among its population, he declared that an appropriation, that would enable the free distribution of iodine tablets to the school children of the county, would insure its total elimination in less than fifteen years.

Last year 700 persons died from diphtheria in New York state compared with 6,500 in 1888. New York has been using toxin-antitoxin intensively. The diphtheria death rate is very small in comparison with the population.

Frequent and thorough physical examinations for everyone and particularly persons of middle age were recommended as the best means of prolonging life and health by Dr. Stephen E. Gavin, Fond du Lac, in a talk on preventive medicine and the lengthening of life before the Waupun Rotary Club. For the individual to ignore the protection afforded by vaccination, innoculation, and similar preventive measures is foolish, he pointed out, and strongly recommended periodic physical examinations to check up on the human mechanism and make the early treatment of disease possible.

Dr. H. A. Schulz, formerly of Ripon, has purchased the equipment and office supplies of the late Dr. C. F. Rehling and has opened an office in the State Bank Building at Fremont.

One of the best means of controlling social diseases is through education, said Dr. M. W. Sherwood, Milwaukee, who spoke on "The Prevention and Control of Social Diseases" at the meeting of the mothercraft class of the Maternity Hospital and Dispensary Association. Dr. Sherwood advocated that the dangers and effects of disease be taught in high schools by competent men and women.

An accessory to the operating room at Muirdale Sanatorium, Wauwatosa, has been added in the form of a talking machine. Music has a soothing effect upon the mind and reduces worry to a minimum at a time when the patient is likely to exaggerate the seriousness of a surgical operation, according to Dr. G. L. Bellis, superintendent. The use of music has been tried in hospitals elsewhere and is said to produce a quieting effect upon patients.

Dr. L. J. Friend, Merrill, who specializes in diseases of the eye, ear, nose and throat, has just closed a transaction by which he will take over the practice of Dr. L. J. DeSwarte, Beloit. Dr. DeSwarte will discontinue the practice of medicine to devote his entire time to private interests. He will make his home at Chicago in the future.

At a meeting of the board of trustees of Sunnyview Sanatorium, held last month, Dr. J. W. Lockhart, Oshkosh, was named as the consulting physician of the institution to fill the vacancy left by the death of the late Dr. Frank Brockway. Dr. R. H. Bitter, Oshkosh, was reappointed as the attending physician of Sunnyview.

Dr. H. J. Sure, Milwaukee physician, returned the latter part of February from a six months' tour of Europe.

Dr. R. J. Jamieson has been appointed physician for the E. M. B. A. at Racine to replace Dr. C. E. Constantine, who resigned recently. Dr. Jamieson will assume his new duties at once.

An elaborate exhibit sent down from Milwaukee by the Wisconsin Anti-Tuberculosis Association was on display at the Y. M. C. A. building, Beloit, as a feature of the observance of Health Week in that city recently. The health program was sponsored by the "Y" and the Physicians and Surgeons Club, with the cooperation of schools, clubs, shops and the health department.

Dr. F. C. Christensen, Racine, acceded to the request of friends to have his name placed on the ballot for the office of school commissioner. In the past he frequently has been urged to seek election as a member of the board of education, but declined.

Dr. O. B. Bock, Sheboygan, was operated upon for appendicitis several weeks ago. His friends throughout the state will be pleased to learn that he is now well on the road to recovery.

Speaking before the Nicolet Parent-Teachers' Association, during a recent meeting in the high school auditorium, De Pere, Dr. George F. Goggins urged a frequent "health inventory," especially for persons who have reached the age of forty years. He stressed the importance of a thorough physical examination once a year to determine the condition of the heart, kidneys, lungs and other vital organs of the body.

"It is doubtful whether any state in the union has reached a lower typhoid fever death rate consecutively for recent years than Wisconsin," said the state health board bulletin in comparing Wisconsin's record for this disease with that of the nation as a whole. The statement was prompted by a bulletin issued by Surgeon-General H. S. Cummings, of the United States Public Health Service.

In 1924, the last year of census figures, the national death rate for typhoid fever was 6.7 per 100,000 people. In Wisconsin the rate in 1924, based on 29 deaths, was 1.0. In 1926, according to latest figures, Wisconsin's typhoid mortality rate was 1.5, based on a total of 42 typhoid deaths. The striking improvement is shown by comparison with 1910, when the state board recorded 558 deaths from typhoid fever.

Dr. Arthur W. Rogers, Oconomowoc, president of the State Medical Society of Wisconsin, delivered messages on "Mental Hygiene" and "How to Keep Well" at

Janesville during their recent observance of Health Week.

The city of Winnipeg was selected as the place for the next annual meeting of the Minneapolis, St. Paul & Sault Sainte Marie Railway Surgical Association. The following officers were elected for the ensuing year at the Minneapolis meeting: President, Dr. Karl W. Doege, Marshfield; Vice-President, Dr. David J. Twohig, Fond du Lac; and Secretary-Treasurer, Dr. John H. Rishmiller, Minneapolis, Minn.

Wisconsin's program against heart disease was highly praised by Dr. Earl R. Templeton, medical secretary of the American Heart Association, who spent several days in consultation with Milwaukee physicians on lowering heart disease death rate. This can only be done, declares Dr. Templeton, by carrying on an intensive, organized campaign similar to the anti-tuberculosis work and he feels that Wisconsin is fortunate in having the work carried on under the leadership of the Wisconsin Anti-Tuberculosis Association and as a part of its program.

Dr. William F. Lorenz, head of the Wisconsin Psychiatric Institute, Madison, was the speaker of the evening at the March meeting of the La Crosse County Community Council. His subject was "A Program of Mental Hygiene in Wisconsin."

Drs. Arthur G. Sullivan and Eugene S. Sullivan, of Madison, have announced recently the opening of a branch office in the Hayes Block, at Janesville. Their practice will be limited to consultations and general surgery.

Seventy-six second year medical students drew lots recently at the University of Wisconsin to determine which of them will make up the quota of thirty-six to which the third year class of the medical school will be limited. To make sure that a representative cross section of the group was chosen to remain, and that no scholastic consideration entered into the choice, the class was divided into three groups—40 per cent including students with grades above 85, 40 per cent with grades between 81 and 85, and 20 per cent with grades below 81.

According to Dr. C. R. Bardeen, dean of the medical school, the final two years of clinical work introduced into the University in 1924 furnished facilities for 25 men its first year and 32 last year.

Dr. J. O. Dieterle, 141 East Wisconsin Ave., Milwaukee, left on March 19th for a clinical visit to the orthopedic centers of Europe. He will return some time in August.

The committee which arranges programs for broadcasting at Stevens Point over WLBL have asked Dr. F. A. Southwick to give a health talk about once a month. Dr. Southwick spoke on diphtheria last month and in the near future will broadcast a talk upon goiter.

Dr. Gerald K. Wooll, Janesville, is asking $1,500 damages for injuries received in an automobile collision accident. Charges of carelessness, recklessness and negligence are made against the driver of the second car.

Surgery is necessary for every human being, regardless of race, creed or color and it has had a big part in lengthening the average span of human life, Dr. V. F. Marshall told the members of the Appleton Rotary Club at the Conway Hotel recently. Dr. Marshall traced the history of surgery from its earliest days and showed how the science has developed and contrasted the dangers and difficulties of surgery a century ago with the efficiency and comparative safety of today.

Dr. Albert J. Boner, clinical director at the Wisconsin Memorial Hospital, Madison, has resigned that position, effective on April 1st. Dr. Boner will continue his post-graduate studies in the east.

Dr. M. A. Flatley of Antigo, who has been spending some time in Florida, is now in New York where he is attending an eye, ear, nose and throat clinic.

Dr. E. L. Tompach, Racine, who has been confined at St. Mary's Hospital for a number of weeks with a fractured hip, has now been removed to his home. The doctor expects to resume his practice in the very near future.

Offering considerable information and many details that were new to his listeners and which afforded a new insight to a topic which has received much discussion throughout the state, Dr. Adin Sherman, superintendent of the Northern Hospital for the Insane at Winnebago, addressed the members of the Candlelight Club at Oshkosh recently. The subject of Dr. Sherman's discussion was "Charitable and Penal Institutions of the State."

Dr. B. P. Mullen, formerly of Sturgeon Bay, has been appointed to the surgical staff of the Presbyterian Hospital at Chicago.

Dr. David T. Long of Whitehall has become associated in practice with Drs. B. J. Steves and J. A. Halgren at Menomonie, Wis. Dr. Long specializes in diseases of the eye, ear, nose and throat. He is a graduate of Emory University, Atlanta, Ga., 1917, and practiced four years in North Carolina prior to taking his post-graduate work at Rush Medical College and University of Chicago, after which he was assistant to Dr. J. A. Stucky of Lexington, Ky.

At the March meeting of the staff of St. Mary's Hospital, Madison, Drs. W. J. Bleckwenn and H. H. Reese of the neurological service, conducted a symposium on the subject of Encephalitis Lethargica or sleeping sickness. They described the epidemics of this disease which occurred three or four years ago, discussed methods of diagnosis and treatment and presented statistics showing the mortality and frequency of residual pathology.

A description of the various late manifestations of encephalitis was well illustrated with moving pictures and the actual demonstration of several cases. Dr. Bleckwenn discussed for Dr. Lorenz, in his absence, the sociological aspect of the disease and brought out the fact that in a recent incomplete poll of Wisconsin physicians over eight hundred recognized cases were reported more than two hundred of which, now hopelessly incapacitated, are unable to earn a livelihood or to pay for the medical care which will be necessary for the remainder of their lives.

Since the paralyses and palsies of late encephalitis are not associated with mental deterioration, these patients are not eligible for hospitalization in the state psychopathic institutions. It was pointed out that the time is not far distant when the state must provide medical care for this increasing group of helpless individuals.

The program was one of the most interesting and instructive presented at the hospital this year. In February the St. Mary's Hospital staff entertained the Dane County Medical Society at the first of a series of meetings which will be held by this society at Madison hospitals during the year. Dr. S. A. Boyce and W. M. Nesbit presented papers on upper respiratory infections and the use of the bronchoscope, respectively. The meeting, which was well attended, was followed by a buffet luncheon served by wives of St. Mary's staff members.

Dr. R. L. Alvarez has returned to Galesville to resume his practice in that city. He was associated with the late Dr. J. J. Powell for some time and is well known at Galesville.

DEATHS

Dr. John J. Powell, Galesville, died on Sunday, February 6th, at his home of heart disease. Dr. Powell was born November 10, 1885, at Winona, Minnesota, and was a graduate of the College of Medicine, University of Illinois, Chicago, in 1913. He was a past president of the Trempealeau-Jackson-Buffalo County Medical Society and has been a member of the State Medical Society of Wisconsin and the American Medical Association for many years.

Dr. Fred R. Lintleman, Janesville, died on March 7th at Mercy Hospital. He was born in 1880 at Malta, Illinois, and was graduated from the Medical School of the University of Iowa in 1904. He practiced his profession at Harlan, Iowa, for a period of nine years. In 1913, he spent a year in New York City, specializing in eye, ear, nose and throat treatments and diseases. In July, 1914, he moved with his family to Janesville where he lived continuously until his death. He is survived by his wife, a son and a daughter.

Dr. Lintleman was a member of the Rock County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Dr. Charles M. Fuson, Jump River, died on March 10th, at a Marshfield hospital, following two operations for ulcers of the stomach. Dr. Fuson was born in the year 1875 and was graduated from the Barnes Medical College, St. Louis, in 1908. He was licensed in the state of Wisconsin in 1920.

Dr. J. F. Brown, Waupun, died on March 21st in that city. Dr. Brown was born in 1863 and was graduated from the Milwaukee Medical College in 1901. He was for many years superintendent of the State Central Hospital for the Criminal Insane at Waupun and since January last, physician at the State Penitentiary. The deceased was formerly superintendent of the State Home for Dependent Children at Sparta and also the Janesville School for the Blind.

Dr. Brown was a member of the Dodge County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Dr. Soren Sorenson, Racine, died at St. Mary's Hospital on March 21st. Death was due to pneumonia. Dr. Sorenson was born in Denmark, April 4, 1861. He was graduated from the Jefferson Medical College, Philadelphia, in 1893, and practiced his profession in Racine since that time. The deceased served on the medical staffs of the State Asylum at Mendota and St. Mary's Hospital, Racine.

Dr. Sorenson was a member of the Racine County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his wife and four children.

CORRESPONDENCE

WISCONSIN HOSPITAL ASSOCIATION

March 5, 1927.

Mr. J. G. Crownhart,
Managing Editor, Wisconsin Medical Journal,
Milwaukee, Wisconsin.

Dear George:

The Board of Trustees of the Wisconsin Hospital Association has decided to hold its 1927 Annual Convention at Milwaukee on May 23 and 24. The meetings will be held at the Hotel Pfister.

Our Program has not been worked out sufficiently for us to give you any material as yet, but we hope to have it in shape in the near future. We will appreciate the information as to just what dates your magazine will go to press for each issue between now and our Convention and we will attempt to give you the very latest information for each issue.

We wish at this time to extend a special invitation to you to be present and to take part in our Convention. We hope you will be able to give us some publicity for our Convention through your magazine and we wish to thank you in advance for such publicity as you may see fit to give us.

Will you kindly include these dates in your calendar of Convention dates, etc.

Thanking you, I am,

Very sincerely,
H. K. Thurston,
Executive Secretary,
Wisconsin Hospital Association.

DONORS

Mr. J. G. Crownhart,
153 E. Wells Street,
Milwaukee, Wisconsin.
Dear Mr. Crownhart:

At the last meeting of the Milwaukee County Radiological Society it was decided to publish* the list of donations received in connection with the annual meeting of the Radiological Society of North America.

As I had the funds in charge, I am very anxious that the enclosed list be published in the State Journal if possible. It is our intention in this way to acknowledge all pledges and donations as a matter of public record.

Very truly yours,

HBP:GS H. B. Podlasky, M.D.

SECTION ON RADIOLOGY

March 23, 1927.

Mr. J. G. Crownhart,
153 Oneida St.,
Milwaukee, Wisconsin.
My dear Mr. Crownhart:

If you have space in the April issue of the Journal wish you would be kind enough to give a little notice to the Section on Radiology of the State Medical Society, which will hold its mid-year meeting at La Crosse, Saturday, May 14th. It will be an all day meeting with clinics, papers and demonstrations of interest to internists, surgeons and to dentists. The meeting will close with a dinner in the evening followed by an address by a man nationally known for his achievements in his specialty.

Dr. James A. Evans of La Crosse is chairman of the program committee and promises to have the program completed in time for the May issue of the Journal.

Sincerely,

C/E Howard Curl, M.D.

A. M. A. SPECIAL

ILLINOIS MEDICAL JOURNAL

March 11, 1927.

Mr. J. G. Crownhart,
Wisconsin Medical Journal,
Milwaukee, Wisconsin.
Dear Sir:

The Illinois State Medical Society is running a special train to Washington, D. C., over the Pennsylvania Railroad for the A. M. A. meeting in May.

Will you, in the forthcoming issues announce this for us in the valued columns of your much-read Journal?

Chicago is the transfer terminal for physicians coming from your district. Travel on this special train will undoubtedly hold many pleasurable features that otherwise would be unavailable. In addition to this opportunity for fraternization among doctors from Illinois and states north and west, there is a certain amount of professional pride in making of this "Special" a banner train.

It might be convenient if you would publish also this enclosed schedule of train service.

Cordially, as ever,

CJW*g Charles J. Whalen.

ILLINOIS STATE MEDICAL SOCIETY SPECIAL TRAINS TO A. M. A. MEETING
PENNSYLVANIA RAILROAD

Lv. Chicago, 1:00 p. m., May 15-16
Ar. Washington, 9:00 a. m., May 16-17

An additional special car service on the LIBERTY LIMITED, May 14th and 17th and the PENNSYLVANIA LIMITED, May 14th, 15th, 16th and 17th.

LIBERTY LIMITED		PENNSYLVANIA LIMITED	
Lv. Chicago,	1:00 p. m.	Lv. Chicago,	5:30 p. m.
Ar. Washington,	9:00 a. m.	Ar. Washington,	4:20 p. m.

Address inquiries and reservation requests to Mr. W. E. Blachley, Division Passenger Agent, Room 524, Union Station, Chicago.

IMPURE LIQUOR

Wauwatosa, March 28, 1927.

Mr. George Crownhart, Editor,
Wisconsin Medical Journal,
Milwaukee.
Dear Mr. Crownhart:

I attach a letter which I have received together with a copy of my reply. Inasmuch as the profession of the state is probably receiving similar letters it occurs to me that this correspondence might well be published in the Journal.

Sincerely yours,
K. E. Kassowitz, M.D.

ASSOCIATION AGAINST IMPURE LIQUOR

Suite 2007-2008
TIMES BUILDING
Broadway & 42nd Street
New York, N. Y.
Telephone: Bryant 1740

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*This list is on file at the State Society office.—Editor's Note.

A. Selwyn-Brown, Ph.D., LL.D., Editor and Author, New York City.
C. H. Freudenthal, Treasurer, New York City.

March 22, 1927.

Dr. Karl E. Kassowitz,
Muirdale Sanatorium for the
Treatment of Tuberculosis,
Wauwatosa, Wisc.
Dear Doctor:

The Association Against Impure Liquor was formed in the interests of public health. Enclosed herewith you will find an outline of the general purpose of the Association which please read carefully, and let us have an expression of your approval.

The Association considers it to be the professional duty of every physician, in those states where the state law does not prohibit, to have a Federal permit, and exercise his privilege under the law. Furthermore, the prescribing physician should see that the liquor prescribed by him is secured from a reputable druggist, holding a permit under the National Prohibition Act.

Many physicians have not taken out Federal permits to prescribe medicinal liquor. It has been suggested that such failure has tended to encourage the public in securing its needs in an irregular manner, which caused liquor procured from illegal sources to be given to the sick without physicians ascertaining its purity or quality.

Will you have the kindness to inform us whether you have taken out a Federal permit to prescribe in your practice? If you have not done so, will you in the interests of public health, reconsider the advisability of complying with the law and give assistance to the proper functioning of the law?

This Association will be pleased to have your valued suggestions and will gladly render any assistance that you might need.

For your convenience, we enclose herewith a self-addressed envelope, and hope to hear from you as soon as possible.

Respectfully yours,
Charles Capehart, *Director*,
Association Against Impure Liquor.

Our Pure Medicinal Liquor Program Has the Endorsement of Hundreds of Prominent Physicians and Citizens Throughout the Country.

OBJECT OF THE ASSOCIATION AGAINST IMPURE LIQUOR

The Association Against Impure Liquor is in no way concerned with any movement for or against the repeal of the laws relating to liquor. Its purpose is to secure a membership comprising physicians, hospital authorities, pharmacists and citizens who realize the necessity for purity in liquors administered to the sick.

It is believed that those to whom medicinal liquor is prescribed by competent physicians are entitled to liquor corresponding to the test of the United States Pharmacopoeia and the therapeutic authorities dealing with medicinal liquors.

It is believed that in the interest of public health and the freedom of the reputable physicians of the country, to comply with the terms of the law, there should be an adequate supply of pure medicinal liquor as readily and as certainly available as other medicines; and that the physicians of the country should feel secure from unfair restrictions, and unwarranted criticism, in prescribing and administering liquor whenever, in their professional judgment, such liquor is required.

It is proposed, through this Association, to urge upon all reputable physicians, to secure Federal permits, and be prepared to prescribe and administer medicinal liquor wherever needed, and to this end, to urge all honorable means of securing relief to the profession from the harassing restrictions now found in the regulations. The effect of these regulations has been to cause many physicians to refrain entirely from securing permits, and prescribing, or administering liquor, lest they endanger their professional standing on account of unwarranted criticism. This Association wishes to aid in protecting reputable physicians, and in adding to the confidence of both physician and patient.

It is a deplorable fact that the burdens placed upon the pharmacists and physicians in securing and administering pure medicinal liquor have led to the use of illicit, in place of authorized, medicinal liquors. Aside from all other considerations, the notorious impurity of the so-called bootleg liquors makes resort thereto, in cases of sickness, a shocking illustration of the disability of the physician to secure pure medicinal liquor when prescribing.

The Association Against Impure Liquor is convinced that, regardless of views on the principle of prohibition, the medical and pharmaceutical professions, and the intelligent public, should generally support the purposes for which it is organized. Its objects are fully within the spirit and intent of the national laws and should have the cooperation and support of all good citizens.

MUIRDALE SANATORIUM
Wauwatosa, Wis.
March 28, 1927.

Association Against Impure Liquor,
Times Building.
Broadway and 42nd Str.,
New York City.
Gentlemen:

In acknowledging receipt of your communication of Mar. 22, 1927, I am glad to answer your request giving my opinion on the problem in which you are interested. However, I wish to say from the beginning that my opinion on most of the points is contrary to that of your association. Permit me to outline the reasons for it.

The question whether a physician should make use at all of his legal privilege to prescribe medicinal liquor, how frequent and in what type of patient he ought to do it or if he should prefer to substitute the large choice of other efficient medicaments, as for instance, heart stimulants, stomachica, tonics, whenever alcoholic beverages might appear to be indicated, this question is a purely medical one and, according to my opinion, should not be dealt with by a body on whose advisory

board five physicians are figuring together with nine laymen.

I do not know whether that board is acquainted with the fact that the whole question of the necessity of using medicinal liquor in pathological conditions is still controversial and that a large number of medical authorities take the stand that in any case there is always a better and safer remedy at hand without the danger of creating a habit through medication. Therefore, I do not consider it "the professional duty of every physician to have a federal permit and to exercise his privilege under the law." Laymen should better refrain from telling physicians about their professional duties and also "from urging upon them to be prepared to prescribe and administer medicinal liquor whenever needed." If they do, they risk to be told to mind their own business and better not try to interfere with matters concerning the medical and ethical conscience alone of every individual physician.

Furthermore, an association specializing in the question of the legal privilege of prescribing liquor for strictly medical purposes ought to be acquainted with the fact that unfortunately there are some among the medical profession with a rather wide conscience in issuing prescriptions more or less indiscriminately to everyone asking and paying for them as long as the prescription book lasts. Whoever might call that an "unwarranted criticism" would probably withdraw in the presence of anyone ready to serve the facts.

Yet the worst experience an impartial social investigator could make is that a few medical men have sold their prescription books with fake names and fake diagnoses to so-called reputable pharmacists for a monthly reward of $100 as a regular addition to their budget, with the result that they have no means of issuing any more prescriptions in the event of an unforeseen emergency. The objections of physicians or laymen justifying these illegal and unethical procedures with the argument that they help to substitute medical bootleg liquor for ordinary impure bootleg liquor cannot be considered "within the spirit and intention of the national laws" but rather fighting those laws, regardless whether bad or good, by malicious and selfish means. The regard for the ethical integrity of the medical profession requires an outspoken criticism for its shortcomings and the esteem for the American Constitution calls for an open attitude either in favor or opposed towards her amendments.

Your communication with the request of giving my viewpoints has afforded me the opportunity to which I was looking forward to formulate my impressions on that problem in a frank way.

Regarding the outstanding importance of this public question, I am confident that you are not going to take these deductions personally.

Very truly yours,

GT K. E. Kassowitz, M.D.

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Benell, Otto E., Coon Valley.
Maercklein, C. M., Sheboygan.
Hoffmier, L. A., Superior.
McEachern, W. A., Superior.
Crane, M. C., Walworth.
Jacobson, T. LeRoy, Delavan.
Zintek, S. S., 1364 8th Ave., Milwaukee.
Salinko, Stephan S., 638 8th Ave., Milwaukee.
Heifetz, Eugene C., Milwaukee County Hospital, Wauwatosa.
Curtin, James G., 215 27th St., Milwaukee.
Matushek, Wm. A., Wausaukee.
Guenther, O. F., Campbellsport.
Sathe, M. R., 9 N. Main St., Fond du Lac.
Yockey, John C., 9 N. Main St., Fond du Lac.
Goggins, G. F., De Pere.
Malcolm, J. J., Edgar.
Kuegle, F. H., Janesville.
Livingstone, J. W., Hudson.
Phaneuf, S. J., Somerset.
Lando, D. H., Elk Mound.
Gates, Eugene, Two Rivers.
Guttman, Paul, Cato.

CHANGES IN ADDRESS

Schulz, H. A., Ripon, to Fremont.
Prentice, J. W., Deer Park, to Amery.
Sanders, Joseph, Rice Lake, to Louisville, Ky.
Walker, L. J., Merrillan, to 48 W. 68th St., New York City.
Gudex, V. A., Eau Claire, to 1211 Booth St., Milwaukee.
Huber, G. W., Merritt, Fla., to Minocqua.

A bill asking for an appropriation of $500,000 for the purchase of new grounds and the erection of new buildings for the Wisconsin Industrial School for girls, now located in Milwaukee, has been introduced in the assembly by Assemblyman Carl Koenig, Sauk County. Under the terms of the bill the board of control would select a new site subject to the approval of the governor.

The state board of control has advocated the removal of the girls' industrial school to some other location and state officers generally are said to feel that the institution should be taken out of the Wisconsin metropolis. The Industrial School for girls was originally on the outskirts of Milwaukee but the city has gradually pushed its way about the institution. The present school is objected to on the grounds that it is located in a city and also because there are no facilities at the school for the employment of inmates. The institution has had considerable trouble with the girls in its confines which included a general strike of the prisoners. The board of control presented a plea for a removal of

the girl's industrial school to the state board of public affairs at the time of the budget hearings.

* * *

Any shop other than a licensed drug store is legally barred from selling aspirin according to an opinion by Attorney General John Reynolds to the state board of pharmacy. The board asked for an opinion on the subject declaring that aspirin is now being sold at shoe shining stands, department stores and other shops that have no right to sell drugs. The opinion held that any shop other than a drug store selling aspirin can be prosecuted.

* * *

Net expenditures of the state and all its political subdivisions have increased from $86,718,954 in 1918 to $190,701,877 in 1924, practically 120 per cent, according to bulletin 25 just issued by the state tax commission.

The bulletin indicates very clearly, according to Judge Charles D. Rosa, member of the commission, that roads and schools are the two main causes of high taxes when looked at from the standpoint of the objects for which the money was spent. Net expenditures of the state government alone, after state aids have been deducted, increased from $11,268,501 in 1918 to $23,398,094 in 1924. The increase in expenditures of counties, upon which the brunt of the road building program has fallen, was the heaviest of any group. Net expenditures increased from $14,968,043 in 1918 to $41,986,193 in 1924. It has practically doubled since 1920 when the net expenditure was $21,665,313.

* * *

There were about 200 more highway accidents in Wisconsin in 1926 than in 1925 with 19 more people killed in the latter year than in the year previous, according to a report just issued by the highway commission.

According to the figures there were 1,354 highway accidents in the state in 1925 with 151 people killed compared to 1,547 accidents in 1926 and 170 killed during 1926.

Railroads had 321 crossing accidents during the last quarter of 1926 with 76 killed and 214 hurt, according to a railroad commission report. Autos were involved in 257 of these accidents with 63 killed and 199 hurt as a result of train-auto crashes.

The railroads had 670 accidents, other than those at crossings, during this period and these accidents resulted in 76 killed and 385 hurt. Twenty-eight of those killed were trespassers.

* * *

The state soldiers' rehabilitation board cannot use or pay out any of the funds provided by law after July 1 of this year, Attorney General John Reynolds held in an opinion to John F. Mullen, director of the pension, bonus and rehabilitation division of the adjutant general's office. The law for the use of such funds was passed in 1919 and was renewed several times but the act definitely ends on July 1.

* * *

A bill to appropriate $8,000 to be used to complete the collecting, classifying, cataloging and editing of historical material relating to the activities and services of Wisconsin soldiers, sailors, marines and nurses in the World War has been introduced in the senate by Senator Oscar Morris, Milwaukee.

* * *

Advertising signs erected or maintained on the public highways of the state or on the line fences along such highways are unlawful and are subject to removal and the persons responsible for their erection are liable to penalties, Attorney General John Reynolds held in an opinion to the state highway commission. The question submitted for opinion was the legality of the actions by a merchant who caused to be attached to wire fences along highway signs which declared the distance to his store. Attorney General Reynolds held that none but official signs are permitted on highway right-of-ways and that it is illegal for merchants to erect signs with warnings or advice to attract attention to their advertisements.

* * *

About 2,200 miles of state trunk highways have been marked and signed according to new regulations, according to a report by the state highway commission. These roads now have the new type of direction marker which is a sign with a black border and with black lettering on a white background. They have also the caution and warning signs which have a black border and black lettering on federal yellow background. Specifications as to shape, size and color for caution and warning signs have now been adopted by the U. S. Bureau of public roads and those in Wisconsin will conform with similar signs throughout the entire United States.

* * *

That a child should have the right to sue his parents when injured through the parent's neglect is the contention of Justice Charles H. Crownhart in a dissenting opinion filed in the supreme court. The supreme court held by a majority in the Laurenta Wick case from Racine "that a child under the custody of the parent may not sue the parent for injuries or wrongs committed by the parent resulting in damages." Claiming that such a decision contravenes the state constitution, Judge Crownhart filed a dissent. Crownhart points out that an infant may sue a parent for damage to property but that the recent decision denies the right to sue for injury to person. The majority opinion bases its edict on the ground of public policy.

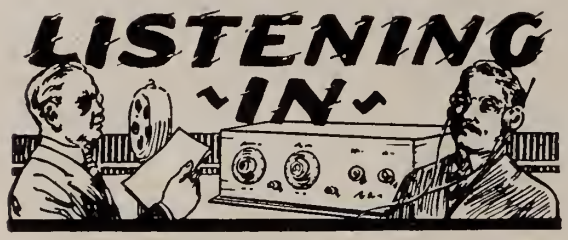
* * *

Liquid weed killers which appeared on the markets of Wisconsin under trade names have been tested by the university department of agronomy and found unsatisfactory, according to A. L. Stone who made the investigation for the department. The weed killer was found to be merely a solution of sodium arsenite to which a small quantity of analine dye had been added. Mr. Stone prepared a solution of sodium arsenite and compared it with the material advertised at a price of $3 per gallon. He found that the sodium arsenite solution costing only 25 cents per gallon was fully as effective as the commercial solution which had been advertised.

* * *

"If the forest fires occurring every spring in northern Wisconsin could be abated, the reforestation problem would be solved." This was the declaration of W. T.

Swan of Oshkosh representing the Hardware Lumber Dealers' Association in an address before the state affairs committee of the assembly. Swan said that it was the fires which broke out every spring in northern Wisconsin which made some parts of the country look like a barren waste. Favorable action is expected from the legislature on Senator Barker's bill giving the State Conservation Commission power to use its agencies in the control of forest fires.



AVOIDING A "TAG"

Practically every city and village has parking laws. Doctors, because of emergency calls, seem to be frequent violators. The red card is torn up when the police learn who it is that has been tagged, but even taking the card to the police station within the specified time is frequently difficult.

One member has found a satisfactory remedy. Attached to his steering wheel is a leather suitcase name-card. In this is inserted his professional card. Should a policeman start to tag his car he learns at once that it belongs to a physician and generally grants some leeway.

REPORTS ADVISABLE

A member asked this question during March: A girl came to the office stating that she was a drug addict but breaking herself of the habit. She asked for a small dose, however, saying that her supply was exhausted. The dose was refused. The girl had given her name and address. Should any report be made?

Officials at the Narcotic Division, Federal Building, Milwaukee, said that no report was required by law, but that physicians were urged to report such cases.

"When such a report is made we offer our assistance to the addict," said the officials, "and endeavor to see that she receives institutional care to break the habit. By so doing we help the patient and keep him or her from other physicians' offices where he may be a nuisance or a cause of unintentional but serious trouble."

A GOOD POSTER

Some time ago the Secretary's office noted that in New York a special card poster on the use of toxin-antitoxin had been distributed. A letter brought one of these most attractive cards. Now the State Board of Health of Wisconsin will distribute them to physicians throughout the state for posting in their waiting rooms.

STREETS CHANGE NAMES

Last month, by city council action, the names of nearly 200 streets in Milwaukee were re-named. Milwaukee physicians residing on such streets were surprised to learn that this constituted a "change of address" and that they must make reports to the federal and state prohibition offices if they held such permits, and to the federal narcotic office if they held a narcotic permit.

REVOCATION OF LICENSE

Due to an unintentional, incomplete statement in a State Board publication explaining proposed changes in the medical practice act, several members have asked if the bill pending proposed to vest in the Board the right to determine and pass upon the question of revoking a license. They have been informed that this is not the proposal.

At the present time a section in the act states that when a physician is convicted of a crime committed in the course of his professional conduct, the court shall revoke his license. The Board has experienced great difficulty in this matter inasmuch as they rarely learned of a conviction before sentence was imposed and then found that the judge had overlooked that requirement in imposing the sentence. As result new actions had to be started to secure the revocation demanded by law.

To insure enforcement of this section the proposed change vests the ministerial power in the Board. Thus, if the bill is enacted, the Board would automatically revoke the license of a physician convicted and sentenced to state prison for a crime committed in the course of his professional conduct. The transfer is not one of judicial power, which question has not been considered in this measure.

AID APPRECIATED

It frequently happens that members receive letters on legislation, information on quackery, and like material which is of importance. It will be a distinct aid to the Secretary if such material is promptly forwarded to him. When convenient enclose the envelope in which it was received.

Marquette to Hold Hospital Clinical Congress in June; Working Exhibits to Feature Meeting

Marquette University College of Hospital Administration has announced plans for the holding of the Hospital Clinical Congress of North America the week of June 20 to 24 inclusive, in Milwaukee.

The Rev. C. B. Moulinier, regent of the College of Hospital Administration, in making the announcement, stated that Marquette University has been working for some time preparing for the congressional exposition. The plan is to set up in the Auditorium in Milwaukee complete working exhibits of modern hospital equipment and demonstrate their use under actual conditions. It will be the first attempt to institute a "working" clinic.

demonstrating the most modern advances in hospitalization.

There will be four distinct departments: Hospital, Public Health, Safety and Research. The Congress will be vitally interesting to all persons interested in hospitalization; hospital superintendents, staffs, trustees, nurse superintendents, engineers, architects, dietitians, those interested in safety, first aid, industrial hospitalization; public health leaders, welfare workers, both public and private.

Dean John R. Hughes of the College of Hospital Administration, of Marquette University, who is preparing the program in conjunction with the advisory committee on arrangements, is planning on bringing to Milwaukee for the Congress many of the most prominent medical and hospital leaders in the country.

Special clinical teams will be supplied by hospitals for the demonstration. Each department will be under the special direction of a clinical director, who will be chosen from among the foremost specialists in their respective fields. The directors will have charge of the demonstrations and the departments for the entire period of the congress.

Night meetings will be held which will be open to the public, aiding in the education of the public on questions of hospitalization. Among the speakers will be outstanding leaders in public life, the professions, business, industry and education.

The Auditorium with its amphitheater type of seating, is especially suited to the clinical demonstration. It is so arranged that each group can be comfortably seated and can see and hear all demonstrations and discussions in each division, and a number of these clinics can be conducted simultaneously.

Dean Hughes has announced two special courses in hospitalization. The first, a short course of 10 days' duration, will be held from June 6 to June 17. The second, a summer course of six weeks, starts on June 27, ending August 6. These courses are to be conducted by instructors who have been selected from the different fields of hospital endeavor from all parts of the country and include men and women who are acknowledged leaders in their respective fields.

This curriculum has been endorsed by the American Hospital Association, by the officers of the American College of Surgeons, by the American Medical Association, and is therefore acceptable to all the national associations interested in the greater efficiency of nursing and all other technical service to the patient in the hospital.

The short course, preceding the clinical congress and the summer course immediately following, offer an unusual opportunity in hospital education.

The detailed program for the Clinical Congress will be completed within a short time and ready for publication. Information on the short and summer courses can be secured from Dean Hughes.

Résumé and Status of Bills of Interest to Physicians; Assembly and Senate Action to April First Listed

MEDICAL SOCIETIES

88A—McDowell. This bill, introduced by request of the State Medical Society, revises and brings up to date the state law chartering the State Society and county medical societies.

Passed by Assembly. Recommended for passage by Senate Committee on Public Welfare.

AFFECTING MEDICAL PRACTICE

274A—Petersen. The present law provides that dentists may secure alcohol for the purpose of sterilizing their instruments without payment of a permit fee. This bill extends the same privilege to physicians and veterinarians.

Advanced in Assembly.

AFFECTING MEDICAL LICENSURE

5A—Duncan. This bill, introduced for the Interim Committee on Taxation, would abolish special legal counsel for the state departments, including the State Board of Medical Examiners.

Advanced in Assembly.

6A—Duncan. This bill, introduced for the Interim Committee on Taxation, provides that the State Health Officer shall be the Secretary for the following state examining boards: Medical, optometry, dental, chiropractic, basic science and pharmacy. Records of the boards would be maintained at the State Capitol.

Killed by Assembly.

68A—Hinckley. The present law provides that a physician convicted of a crime in the course of his professional conduct shall have his license revoked. This bill provides that the court "may" do so instead of "shall," and further, should the license be revoked, empowers the court to restore the license.

Killed by Assembly; reconsidered 52-31; amendment introduced; re-referred to Committee on Public Welfare.

The amendment so changes the bill that when adopted the bill will then only provide that in cases where a physician's license has been revoked for a first offense, it may be restored by the Court upon written approval of

the President of the State Board of Medical Examiners.

102S—White; 151A—Seftenberg. These are identical bills introduced in both Senate and Assembly. In brief this measure defines roentgenology as the use of the x-ray and "all other electrically produced rays for the diagnosis or assistance in establishment of diagnosis of pathology and the treatment of the human body." It then provides for a special board of examiners to examine all who, now or in the future, desire to use such methods. License fee would be $25 and $5 for annual renewal. This measure would affect, with comparatively few exceptions, all physicians now in practice. Present technicians would also be licensed.

The Assembly bill (151A) recommended unanimously for killing by Assembly Committee on Public Welfare after rejecting a proposed substitute amendment. Substitute amendment introduced on Assembly floor by Mr. Seftenberg.

Substitute in brief provides:

Physicians:

1. Now licensed:
   a. Operating an x-ray on Feb. 1, 1927—licensed without examination, fee $2.00.
   b. Not operating an x-ray on Feb. 1, 1927—licensed by examination by State Board of Medical Examiners, fee $2.00.
2. Future physicians—x-ray to be a subject in regular examination.

Dentists—Osteopaths—Chiropractors:

Same provisions as above under respective boards.

Technicians:

1. Practicing in state for last three years—licensed by State Board of Medical Examiners without examination.
2. All others: Licensed by State Board of Medical Examiners upon basis of—
   A. Good moral character.
   B. High school education.
   C. Competency certified to by two physicians.
   D. Fee of $10.00.
   E. Examination on qualifications to operate and manipulate apparatus producing or used to produce the x-ray.

Technician's License Authorizes:

1. Maintenance of an independent laboratory.
2. Diagnosis to patient's physician.
3. Treatment in such independent laboratory under direction *or authorization* of a person licensed to treat the sick.

Assembly bill and substitute killed 72-2. Senate bill withdrawn on March 30th.

168S—Morris. This bill is introduced by request of the State Board of Medical Examiners. Its provisions are:

1. Abolishes special legal counsel.
2. Provides that foreign applicants must have first citizenship papers and have foreign credentials translated by Board. Raises license fee for foreigners from $25 to $50.
3. Present law pertaining to measures is scattered through three sections. This is compiled into one section.
4. Substitutes one examiner for masseurs instead of three.
5. Provides that the Board, rather than the Court, shall revoke licenses of those convicted of a crime in the course of their professional conduct.
6. Provides that applicants for license to practice medicine and surgery must have completed internship.
7. Provides that fee for reciprocity (now $50 in all cases) shall not be less than $50 and shall be equal to fee charged Wisconsin applicants in state from which reciprocity is desired.

Passed by Senate.

239A—Withrow. This bill is introduced by request of the State Board of Medical Examiners. It provides for an appropriation of $5,000 annually to the board for the purposes of law enforcement efforts.

Recommended for passage by Assembly Committee on Public Welfare. Advanced by Assembly 86-3. Referred to Joint Committee on Finance. Recommended for passage 13-0.

GENERAL HEALTH MEASURES

219S—Teasdale. A bill to empower the State Board of Health to adopt and enforce rules and regulations governing the purchase, sale and distribution of shoe dyes, poisonous fireworks, cosmetics, or other poisonous or noxious products other than food or drug products. This bill carries out preventive measures suggested by the American Medical Association.

Pending in Senate.

182S—Hunt. This measure provides that lye shall be labeled as poison and two antidotes listed on the label. This is a uniform state bill fostered by the American Medical Association and the State Medical Society of Wisconsin.

Pending in Senate.

Committee Rejects Amendment to Change Composition of Medical Board

The bill proposed by the State Board of Medical Examiners was heard by the Senate Committee on Education and Public Welfare on March 2nd. Mr. J. G. Crownhart briefly outlined the bill to the committee, calling their attention to the fact that for the most part the changes were of an administrative character and to bring up-to-date sections of the law which had not been changed since 1915. Dr. Robert E. Flynn, Secretary of the State Board of Medical Examiners, then told the committee the reasons for the changes.

An amendment to the bill was proposed by Dr. Dexter Witte, Milwaukee, on behalf of the Milwaukee County Medical Society. Dr. Witte's amendment pertained to the appointing of the board. It would strike out the present section which requires that the eight members shall be composed of three allopaths, two homeopaths, two eclectics and one osteopath and would substitute therefor "All members shall be licentiates of the board.

seven to practice medicine and surgery and one to practice osteopathy."

Dr. Witte stated that the early growth of medicine was a history of divisions and pointed out that at the time this law was enacted (1897) there were then in existence certain so-called "Schools of Practice." He told of the homeopathic school and the eclectic school and their purposes and then pointed out that since that time the non-sectarian schools had absorbed that which had been found beneficial.

No Eclectics; One Homeopath

"As result," declared Dr. Witte, "whereas in 1901 there were twenty-two homeopathic schools, there are today but two such schools in existence. In 1901 there were ten eclectic schools but today there is but one in existence. Furthermore, during the period 1921 to 1925 inclusive, there were no eclectics applying for license in Wisconsin and but one homeopath.

"The American Medical Association Directory lists some 2,900 physicians as residing in Wisconsin. In compiling this directory each physician is asked if he desires to list himself as practicing an exclusive system of medicine. A search of the last directory reveals the fact that there are but twenty-four homeopaths in all Wisconsin who desire to be so listed. Further, there were but eight eclectics who desired to be listed as practicing, exclusively, as eclectics. When we consider that twenty four homeopaths have thus two representatives on the board and eight eclectics have two representatives on the board whereas approximately 2,875 physicians practicing non-sectarian medicine have but three representatives on the board. I believe it is plain that the time has come when the law should be changed.

"The proposed change," continued Dr. Witte, "is not designed to work a hardship on anyone but on the contrary, to remove an arbitrary limitation on the Governor's appointive power, which, in the very near future, will be impossible of continuance. I desire to point out to the committee that the fact that we substitute seven licensed to practice medicine and surgery does not mean that the Governor may not appoint an eclectic or a homeopath or two of each if he so desires."

The proposed amendment was opposed by Dr. Royal C. Rodecker, Holcombe, President of the State Board of Medical Examiners, who stated to the committee that he was appearing as secretary of the Wisconsin Eclectic Society.

Rodecker Opposes Change

"I do not know," declared Dr. Rodecker, "just how Dr. Witte worked out his figures but I do know that there were about eighteen at our last annual meeting in Milwaukee during May, 1926. However, the Wisconsin Eclectic Society is chartered by law and eclectics have representatives on the board in many states of the Union. How many years we will remain in existence we do not know. It is true that we are not progressing very fast and with the court action driving out nefarious colleges, there remains but one eclectic school at Cincinnati.

"As long as we are still holding meetings, however, we should not be wiped off the board. Our society has eighteen or twenty members in good standing and I have a large list of other men who are eclectics in the state."

"Do you differ from the non-sectarian practice?" asked Senator Hunt of River Falls.

"No, sir, we do not," replied Dr. Rodecker. "There is no great essential difference. The word 'eclectic' is taken from the Greek and means 'I choose.' In closing I wish to emphasize again my statement that so long as the Wisconsin State Eclectic Society, chartered by law, remains in existence, the representation on the State Board should not be wiped out."

The Committee subsequently recommended the bill for passage, rejecting the proposed amendment. The amendment was not offered from the Senate floor.

Assembly Bill to License Independent X-Ray Technicians Killed 72-2

By votes of 69-9 and 72-2 the Assembly killed an amendment, substitute amendment and the original bill, all proposing to license x-ray technicians. The vote came during the last week in March and followed a half hour discussion in the House when the overwhelming sentiment against this licensure measure was evidenced on every hand.

When the bill was called Assemblyman Seftenberg offered an amendment to the substitute modifying the terms of the substitute measure. Discussion turned immediately to the real proposals in the measure, however, and several assemblymen were still asking recognition when the debate was ended upon a motion for the previous question.

"Even though this measure is cut down until it simply licenses a technician to be a technician, it is apparent that the effort started in this original bill will be continued until technicians are permitted to diagnose," declared Assemblyman L. D. Eastman, of Lancaster. "If we enact this it will simply lead to something else."

"Who is asking for this legislation?" asked Assemblyman (Dr.) A. J. McDowell, Soldiers Grove.

"An x-ray technician," was Mr. Seftenberg's answer.

"Are any of the medical profession asking for this?" continued Dr. McDowell.

"No."

"Under the present law, who makes the most use of the x-ray?" asked Dr. McDowell.

"Why, physicians—" said Mr. Seftenberg.

"I agree," said Dr. McDowell, "that physicians are making the greatest use of the x-ray and I point out that it is not these men that are asking for this bill. I ask if any physician is asking for this bill?"

"Well, one physician appeared for it," was the answer.

"If we license people without the basic knowledge," said Dr. McDowell to the Assembly, "the people will go to them and secure what they think is service but what in fact is practice based upon ignorance."

"The purpose of the introduction of this measure is to open up a brand new field of practice by those least qualified," was the statement of Assemblyman Henry Staab, Milwaukee, chairman of the Assembly Committee on Public Welfare, which had recommended the bill for killing. "We demand preparation for the practice of law, for the practice of dentistry and for all other professions and this is in the public interest. When it comes to the x-ray, physicians should have control of it. It is a problem and always has been and its main use is photographic. Personally I never knew of a case where x-ray treatment cured anyone and I mention that to point out that if it is an efficacious remedy it is only so in selected cases where the greatest possible judgment is exercised. I hope that the amendment will be rejected."

READS LETTERS

The argument against the bill was continued by Assemblyman Anton G. Schauer of Kewaunee, who read extracts from two letters from physicians in his county. He declared that this bill would increase the cost to patients and that his home physicians believed it to be a dangerous matter.

"Last session this legislature passed what is known as the Basic Science law," said Assemblyman Frederick J. Peterson, Milwaukee. "It was a law necessary for the protection of the people and requires the same basic education of all who will treat the sick. It may be but little recognized by the public now but I declare that it is the best measure for the public that this legislature has passed in the last twenty-five years. Its value to the public will be increasingly recognized as years pass on and the time will come when its true worth and value will be known throughout the state.

"Here we have an entirely different bill. Overlooking the basic educational requirements, this bill would build a fence around a few. I consider it an exceedingly dangerous precedent and hope that the bill and all amendments will be killed."

"I, too, believe this measure is dangerous to the public," declared Assemblyman William C. Coleman, secretary of the Federation of Labor of Milwaukee. "This bill is essentially for the protection of ten or twelve technicians. Every reputable medical school is now giving x-ray courses and people have an assurance of protection at the hands of those who are licensed to use it. If this bill is passed, the technician of today, with no standard of training, will get a recognition before the public to which he is not in the least entitled."

"I have heard mention of the x-ray as it pertains to treating the sick," said Assemblyman Elmer H. Baumann, Milwaukee, "but we have overlooked the fact that one of the greatest uses of the x-ray today and in the future, is the analysis work in industry. If this bill became a law, there is serious question whether it would not require operators in industry to be licensed."

At this point Assemblyman Math Koenigs, Fond du Lac, moved the previous question and declared that everyone knew how he was going to vote. The speaker held the motion in abeyance.

EVANS' LETTER READ

Assemblyman Gardner R. Withrow, La Crosse, obtained recognition to read a letter from Dr. Edward Evans of La Crosse, chairman of the Council of the State Medical Society. Dr. Evans' letter read before the Assembly follows:

La Crosse, March 23. 1927.

Mr. Gardner R. Withrow,
Member of Assembly,
Madison, Wis.
My dear Mr. Withrow:

There is pending in the Assembly, Bill No. 151-A which I would like you to look into very carefully before consenting to its passage.

I believe it would not only work a great hardship on reputable medical men who may be using the x-ray, and for the use of which by the way they are legally as well as morally responsible, inasmuch as they are subject to the penalties of malpractice if they misuse it, but it would also allow a body of men who might feel disposed to put in an x-ray and hold themselves out as x-ray specialists, to do a great deal of harm. Merely because a man may take technical training enough to understand the physics and mechanism of the x-ray and learn even how to take fairly good x-ray pictures, it would not qualify such a person to understand the complicated mechanism of the human body and the diseases pertaining to the different organs and thereby, it would be very easy for him to do a great deal of harm, be-

cause of his inability to understand diseased processes and their proper supervision.

I am speaking, not as an individual, but as chairman of the Council of the State Medical Society, and as one quite familiar with the view of the profession of the state of Wisconsin, who feels that this would be a distinct evil, inasmuch as it would allow men entirely unqualified beyond ability to operate an x-ray machine, to understand the underlying diseased conditions for the discovery of which the x-ray in the hands of a capable, well-trained medical man is often very helpful.

Yours very truly,

EE/m Edward Evans, M.D.

Assemblyman Edward F. Hilker, of Racine, asked permission to ask a question of Assemblyman Baumann. The permission granted, he then said that he would like to use the x-ray on a few card sharks and asked Mr. Baumann if he would have to have a license under this bill. The last question resulted in several requests for a vote and the amendment to the substitute amendment was killed 62-9.

With the killing of this amendment, Assemblyman Seftenberg declared that he did not desire to see either the substitute amendment or the bill enacted without the amendment, which had been killed, and so moved that they both be killed. In the midst of a vivavoce vote there was a demand for roll call and roll call was ordered. The final vote on the original bill resulted in its death 72-2.

SENATE BILL WITHDRAWN

Following decisive defeat of the Assembly X-Ray Bill on Tuesday, March 29th, Senator White secured unanimous consent to withdraw the companion bill, 102-S, in the Senate on Wednesday, March 30th. This means that all proposed legislation pertaining to x-ray technicians has been killed.

Technician Proponent of Bill

Proponents of the bills to license x-ray technicians were disclosed for the first time at a hearing on the Assembly bill (151A) held early in March. Those who spoke for the original measure were Mr. Donald B. Campbell, an x-ray technician of Oshkosh; Dr. Edward J. Campbell* of Oshkosh; Mr. John C. Thompson, Jr., Oshkosh attorney and former assemblyman, and Assemblyman Seftenberg who introduced the Assembly bill for the proponents.

At this hearing, March third, opposition to the original bill was led by chiropractors. After a two hour hearing during which proponents of the bill showed pictures of x-ray burns to emphasize the necessity for legislation, Mr. J. G. Crownhart, Secretary of the State Medical Society, asked the Committee on Public Welfare to hold a second hearing in two weeks. Mr. Crownhart explained that he had appointed a special committee from the Society to work on the basic questions involved in this measure and that this work had not been completed. The postponement was allowed.

Substitute Amendment Proposed

The second hearing, March 16th, was again opened by proponents of the bill who, dropping the original form almost in its entirety, offered a substitute bill (see digest of bills for terms of this substitute). While the new board feature was dropped the substitute still retained the essential feature that licensed technicians might operate independent laboratories and therein make a diagnosis to a physician and treat not only under his supervision, but upon his authorization as well. Licenses would be issued by the State Board of Medical Examiners and technicians who have been in the state for three years would be exempt. Chiropractors appeared in favor of the substitute measure.

Mr. Crownhart opened the opposition to the bill and substitute in any form by presenting the report of the special committee on the general subject. He explained that he was not concerned with details of operation of the original bill, the substitute, or any other amendment but was presenting the report of the Society on the main question involved.

"As the Committee knows," said Mr. Crownhart, "when this measure came to my attention I asked physicians of this state to aid in gathering information for the benefit of this Committee on Public Welfare. We have spent a month in gathering all evidence and information that we could find. We have gone from New York to New Orleans in consulting those most familiar with the questions this legislation presents. No effort was made to say what our conclusions would be or should be until we had all our information before us. Even then we held a special conference with proponents of the bill at our expense that we might secure any additional evidence they possessed. Following that conference and many others, we came unanimously to the opinions expressed in this report." (Copy sent to all members and published following this article.)

*Not a member of the Winnebago County Medical Society.

Others appearing in opposition to the bill included Dr. H. B. Podlasky, Marquette University and District Councilor of the Radiological Society of North America, Mr. John E. McIntosh of the Victor X-Ray Corporation, Mr. H. E. Pengelly of the Pengelly X-Ray Company, and dentists representing the State Board of Dental Examiners and the Wisconsin Dental Association.

Chairman Henry Staab, Milwaukee, put an end to cross-examination tactics of the proponents after they had asked Mr. McIntosh and Mr. Pengelly if they did not sell most of their apparatus to physicians and if it was not true that they must follow that group, and to Mr. Crownhart if he had not used the same argument against the chiropractors two years ago.

Following the hearing the Assembly Committee reported that they had unanimously rejected the proposed substitute and reported the original measure for killing.

Charge Secretary Influenced

A few days after the hearing proponents of the bill sent a mimeographed statement of their position and a copy of the proposed substitute to physicians quite generally throughout the state. An unsigned (Committee in Favor of the Bill) letter charged that a group of Milwaukee roentgenologists had "sought out and influenced" the Secretary of the State Medical Society "for apparently selfish reasons."

The apparent purpose of the letter was to split the recommendations and force of the State Medical Society statement by securing endorsement of the bill from members throughout the state.

Original Research by the State Medical Society of Wisconsin on Questions Raised in Assembly Bill 151A and Senate Bill 102S

Two Major Questions

Two major questions are presented in this proposed legislation: 1. Has the public sufficient assurance of competence and safety in the field of Roentgenology from those who may in the future be licensed to treat the sick and who may subsequently use the x-ray in their practice for diagnosis, treatment or both?

2. Should x-ray technicians be licensed either
   a. In their present capacity,
   b. To diagnose independent of immediate supervision of one now licensed to treat the sick, or
   c. To treat independent of immediate supervision of one now licensed to treat the sick?

The Present Situation

Before discussing the questions raised we may well summarize the present situation as it exists today.

M. D. This is the only class licensed to use the x-ray for both diagnostic and treatment purposes.

Technician. Some physicians who specialize in roentgenology, hospitals, clinics and some general practitioners have found that they may save time for themselves and thus reduce the cost to the patient, if they train office assistants to do some of the mechanical work of operating the x-ray apparatus. Such assistants are called technicians. They are not licensed and cannot legally diagnose or fix the periods or kind of treatment.

Osteopath. The osteopathic physician may use the x-ray for diagnostic aid but treatment by the x-ray is not "osteopathy."

Dentist. Dentists may and frequently do use the x-ray as a diagnostic aid but do not treat by such means.

Chiropractor. The chiropractor may use the x-ray as a diagnostic aid but the use of the x-ray for treatment purposes is not the practice of "Chiropractic."

First Question

We find that the present laws governing examinations for all classes of those who treat the sick include the statement that the respective examining boards shall conduct examinations in the subjects usually taught in reputable schools of their respective classes. We further find that the use of the x-ray is a subject taught by reputable schools in each and all classifications. Each present licensing board is, therefore, under existing legislation, required to examine in such subject.

Conclusion: We are confident that no examining board will refuse to follow a legislative mandate and if such examinations are not now given it is only for the reason that it has not been called to their attention. Having now been called to their attention we are confident that all future examinations will include this subject. This will, we believe, give the public the assurance of safety and competence from those licensed to treat the sick in the future without the necessity of any additional legislation.

Second Question

A careful search of the statutes and pending legislation in all states discloses the fact that no state now licenses or examines into the qualifications of technicians.

On the other hand we find that the Board of

Health of New York City has specifically legislated against the independent use of the x-ray by a technician. Prior to February 6, 1926, a technician whose knowledge, experience and qualifications were satisfactory to that Board was specifically permitted to operate x-ray apparatus in an independent laboratory. On February 6, 1926, the Board issued the following statement and amended regulation:

"X-Ray Laboratories Regulated. In view of the fact that diagnosis must practically always be based not merely on the appearance of the x-ray film or picture, but on a combination of the facts revealed by the picture and by the clinical history as well, and because this calls for a high degree of medical training and clinical knowledge, the Health Department is constrained to protect the public health by restricting the conduct and maintenance of x-ray laboratories to those who have thoroughly qualified to treat and diagnose disease. Correct diagnosis based on x-ray pictures is possible only when there is a background of adequate education and of rich experience in the various pathological conditions that may closely resemble each other. Moreover, a case of pulmonary tuberculosis, for example, when studied by the roentgenologist, as a rule presents great difficulties in diagnosis. An error in diagnosis, which is inevitable where an adequate medical education is lacking, may condemn the patient to a tragic end and be responsible for the spread to others of unrecognized tuberculous disease. On this account we have felt, that as official guardian of the public health, the defectively worded regulation had to be changed forthwith in the interest of the public health. As amended by action of the Board of Health on February 6, 1926, the regulation *now* reads as follows:

" 'Every x-ray laboratory shall at all times be in charge of and under the direction of a duly licensed physician or other person *who is licensed under the laws of this state to diagnose and treat diseases* and whose knowledge, experience and qualifications to use an x-ray machine are satistory to the Health Department.'

"Thus amended, the regulations will entitle all the members of professions licensed under the laws of the state to maintain and conduct x-ray laboratories and will safeguard the public from errors of omission or commission that might jeopardize life and health."

Shall Technicians Be Licensed As Such?

We now come to the questions of whether it would be in the public interest to license technicians enabling them to conduct separate laboratories even though they did not diagnose or treat independently. After careful investigation we find that this would not be in the public interest for these main reasons:

1. For the reasons cited by the Board of Health of New York City.

2. Should the state license a technician either as a "Technician," "Expert X-Ray Technician" or by other similar title such name and license would mean to the public that the licensee was a "Specialist" in that line. As result there would be a continual temptation to the licensee to exceed the bounds of his license and enforcement of such bounds in the public interest would indeed be most difficult.

3. In 1915 the Wisconsin legislature granted blanket authority, without license, to reputable practitioners of chiropractic. When at a later date licensure was required it appears that over a hundred were treating the sick in this state, not as chiropractors, but cloaked in that name. We submit that should x-ray technicians be licensed any quack might use a technician's license as a cover and cloak for his illegal practice. Again experience has taught that proper law enforcement in the public interest would be most difficult and we are convinced that quackery would use this new form of license to prey upon the sick.

4. We find, moreover, that under the present system the public has recourse should either a physician or his immediate technician employee cause a burn through malpractice. Every physician is insured against such contingency. Thus if malpractice is found to exist, at least the patient is assured of financial compensation so far as it may be compensation. We find, however, that were technicians licensed there is no company known to us that would accept them as a risk except at prohibitive rates with the result that most of them would be uninsured. For that reason a patient sustaining malpractice at the hands of an independently licensed technician could not be certain of even a just financial compensation to care for him during his period of incapacity.

5. We believe that such legislation will tend to take the x-ray out of the office of those licensed with a resulting increased cost to the public.

(Continued on Page XXII.)

THE JOURNAL BOOK SHELF

Shell Shock and Its Aftermath. By Norman Fenton, Ph.D., Associate Prof. of Psychology. Ohio University. Illustrated. Price $3.00. C. V. Mosby Company, St. Louis, 1926.

Practical Surgery of the Joseph Price Hospital. By James William Kennedy, M.D., Surgeon to the Joseph Price Hospital, Philadelphia; Consulting surgeon to the Norristown, Coatesville and Chambersburg Hospitals; formerly in charge of the Gynecological and Obstetrical Department of the Philadelphia Dispensary. Illustrated with 120 original half-tone plates, some in colors. Price $10.00 net. F. A. Davis Company, Philadelphia, 1926.

Transfusion of Blood. By Henry M. Feinblatt, M.D., Asst. Clinical Professor of Medicine, The Long Island College Hospital, Brooklyn, N. Y. Illustrated by 24 engravings. The Macmillan Company, New York, 1926.

Nasal Accessary Sinuses. Pathology and treatment of the inflammatory diseases of the nasal accessory sinuses. By Prof. Dr. M. Hajek, Chief of the Laryngo-Otological Clinic, University of Vienna. Translated and edited by Joseph D. Heitger, M.D., Louisville, Ky., and French K. Hansel, M.D., St. Louis, Mo. Price $17.00. Fifth edition, completely revised and enlarged. C. V. Mosby Company, St. Louis, 1926.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared original articles by leading members of the medical profession throughout the world. Volume IV, thirty-sixth series, 1926. J. B. Lippincott Company, Philadelphia and London, 1926.

Readings in Abnormal Psychology and Mental Hygiene. Edited by W. S. Taylor, Prof. of Psychology in Smith College, with an introduction by Joseph Jastrow, Prof. of Psychology in the University of Wisconsin. D. Appleton and Company, New York and London, 1926.

Physiology and Biochemistry in Modern Medicine. By J. J. R. Macleod, M.B., Prof. of Physiology in the University of Toronto. Toronto, Canada; assisted by Roy G. Pearce, A. C. Redfield, N. B. Taylor and J. M. D. Olmsted. Fifth edition, with 291 illustrations, including 9 plates in colors. Price $11.00. C. V. Mosby Company, St. Louis, 1926.

The Practice of Medicine. By A. A. Stevens, M.D., Prof. of Applied Therapeutics in the University of Pennsylvania. Second edition, entirely reset. Octavo of 1174 pages. Cloth, $7.50 net. W. B. Saunders Company, Philadelphia and London.

Principles and Practice of Chemotherapy, with special reference to the specific and general treatment of syphilis. By John A. Kolmer, M. D., Professor of Pathology and Bacteriology in the Graduate School of Medicine, University of Pennsylvania. Pages, 1,106, with 82 illustrations. Price, cloth, $12.00, net. W. B. Saunders Company, Philadelphia and London.

A Manual of Pharmacology and Its Application to Therapeutics and Toxicology. By Torald Sollmann, M. D., Professor of Pharmacology and Materia Medica in the School of Medicine of Western Reserve University, Cleveland. Third edition, entirely reset. W. B. Saunders Company, Philadelphia and London.

Report of the Department of Health of the City of Chicago for the Years 1923, 1924, and 1925. By Herman N. Bundesen, M. D., Commissioner of Health, Chicago. 1926.

South America. A guide book for lay and professional travelers. By Franklin H. Martin, M. D., in collaboration with William J. Mayo, M. D., Francis P. Corrigan, M. D., and Edward I. Salisbury, M. D. Price. $3.00. Fleming H. Revell Co., 158 Fifth Ave., New York City.

An Introduction to the Practice of Preventive Medicine. By J. G. Fitzgerald, M. D., Professor of Hygiene and Preventive Medicine and Director, School of Hygiene and Connaught Laboratories, University of Toronto; assisted by Peter Gillespie, Professor of Civil Engineering, University of Toronto, and H. M. Lancaster, Chief Dominion Analyst, Department of Health, Canada. Second edition. Price, $7.50. C. V. Mosby Company, St. Louis, 1926.

History Taking and Recording. By James A. Corscaden, M. D., Associate in Obstetrics and Gynecology, Columbia University, New York. Price, $1.50. Paul B. Hoeber, Inc., New York, 1926.

BOOKS RECEIVED FOR REVIEW

Modern Practice of Pediatrics. By William Palmer Lucas, M.D., Prof. of Pediatrics, University of California Medical School. Price $8.50. The Macmillan Company, New York.

Mineral Waters of the United States and American Spas. By William Edward Fitch, M.D., attending physician, Vanderbilt Clinic, College Physicians and Surgeons, New York City. Illustrated. Lea and Febiger, Philadelphia and New York, 1927.

Health Supervision and Medical Inspection of Schools. By Thomas D. Wood, M.D., college physician, adviser in health education, and professor of physical education, Teachers College, Columbia University, and Hugh G. Rowell, M.D., physician to the Horace Mann Schools, lecturer and assistant physician, Teachers College, Columbia University. Octavo of 637 pages, with 243 illustrations. Cloth, $7.50 net. W. B. Saunders Company, Philadelphia and London, 1927.

Physicians of the Mayo Clinic and Mayo Foundation. A series of 635 biographical sketches with 611 portraits and including complete and accurate data concerning the professional life of each physician prior to January 1, 1926. Octavo volume of 578 pages. Cloth, $7.00 W. B. Saunders Company, Philadelphia and London.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared original articles by leading members of the medical profession throughout the world. Vol. 1, 37th series, 1927. J. B. Lippincott Company, Philadelphia and London.

The Diseases of Infants and Children. By J. P. Crozer Griffith, M.D., Prof. of Pediatrics in the Graduate School of Medicine of the University of Pennsylvania, and A. Graeme Mitchell, M.D., Prof. of Pediatrics, College of Medicine, University of Cincinnati. Second edition, reset. Two octavo volumes totaling 1715 pages

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Rice & Thompson, 117 N. Fourth St., La Crosse.
Schumacher Shoe Co., Madison
Walk-Over Boot Shop, Madison
Sol Friedstein & Sons Co., Marinette
Mr. H. J. Tuchscherer, Menasha.
Kundert's Shoe Shop, Monroe
Nelson Shoe Store, Racine
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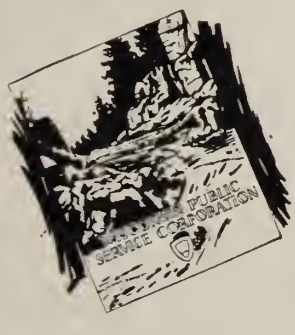

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A Text-book of Clinical Neurology. By Israel S. Wechsler, M.D., Assistant Prof. of Clinical Neurology, Columbia University, New York; Attending Neurologist, The Montefiore Hospital, New York. Octavo volume of 725 pages with 127 illustrations. Cloth, $7.00. W. B. Saunders Company, Philadelphia and London.

Harelip and Cleft Palate. By Matthew N. Federspiel, M.D., Prof. of Oral Surgery, Marquette University, Oral Surgeon, Milwaukee Hospital, Marquette University Hospital and Federspiel Dental Polyclinic. History, etiology, development, anatomy, physiology, types, surgical and nonsurgical treatment, and reported cases. Illustrated. Price $5.00. C. V. Mosby Company, St. Louis, 1927.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 153 Oneida Street, Milwaukee, Wisconsin. These new books will be loaned for an inspection period only.

Hospital Housekeeping and Sanitation. By Nora P. Hurst, R.N. Price $1.25. C. V. Mosby Company, St. Louis, 1926.

This volume is intended for use as a text for the student nurse and all demonstrations are given in considerable detail.—M. C. P.

A Manual in Preliminary Dietetics. By Maude A. Perry, B.Sc., Director of Dietetics, The Montreal General Hospital, Montreal. Price $1.25. C. V. Mosby Company, St. Louis, 1926.

A course in preliminary dietetics is outlined in this manual; the course covers fifteen lessons of three hours each. Theory, demonstration, and practical laboratory work are combined; however, the lessons may be subdivided easily if some other method of teaching is preferred.—M. C. P.

A Primer for Diabetic Patients. By Russell M. Wilder, M.D., Section on Nutrition, Division of Medicine, Mayo Clinic. A brief outline of the treatment of diabetes with diet and insulin, including directions and charts for the use of physicians in planning diet prescriptions. Third edition, reset, 134 pages. Price, $1.50 net. W. B. Saunders Company, Philadelphia and London, 1927.

With insulin available the diet of the diabetic patient need no longer be on a starvation basis. The carefully planned diet is of even more importance with the use of insulin than without, since most disastrous results will be obtained if the proper balance is not maintained between insulin dosage and food intake.

The method of calculation of fuel values of various foods, suggested diets, and numerous recipes are given.
—M. C. P.

Medical Clinics of North America. Vol. X, No. 4, New York Number. W. B. Saunders Company, Philadelphia and London, 1927.

This volume of the Medical Clinics is unusually interesting. An article by I. W. Held on anemia sums up the most recent work and gives a very good picture of the present state of our knowledge of this important condition. Other subjects dealt with are, Peptic Ulcer, Subacute Nephritis, Syphilis of the Nervous System, The Treatment of Arthritis (a description of a new method), Neurasthenia and a number of interesting clinical case reports.

Such résumés as this series of volumes represent, serve to give to the busy man most of the new developments in Medicine. They can be recommended for that reason, if for no other.—L. M. W.

Four Thousand Years of Pharmacy. An outline history of pharmacy and the allied sciences. By Charles H. LaWall, Ph.M., Prof., of Theory and Practice of Pharmacy and Dean of the Philadelphia College of Pharmacy and Science. Illustrated. J. B. Lippincott Co., Philadelphia and London.

This very comprehensive book on the history of Pharmacy in the English language is most welcome. The author goes into the history of medicine, chemistry, alchemy and allied subjects sufficiently to connect them with the general advance in human knowledge, and the book is richly illustrated. It is not a critical work but should stimulate interest in the history of pharmacy and therapeutics and is a worthy addition to any library. We hope that the book will be given the cordial reception which it deserves.—A. S. L.

Human Pathology. A Textbook by Howard T. Karsner, M. D., Prof. of Pathology, School of Medicine, Western Reserve University, Cleveland, Ohio. With an introduction by Simon Flexner, M.D. Illustrations, 20 and 443, black and white. J. B. Lippincott Company, Philadelphia and London.

The study of pathology has, in recent years, developed to such an extent that it requires a very large volume to do justice to the entire subject. Books on pathology may be roughly divided into two general groups. Those which attempt to cover the entire subject and those which treat it sufficiently for text-book or teaching purposes.

This book falls into the latter group and is at the same time sufficient for the physician in general practice. It is well written and covers some subjects rather extensively for its size. The gross illustrations are exceptionally good but the microscopical pictures are considered only fair. At the beginning of each chapter there is a short synopsis which gives the reader a picture of its contents in a glance. The references are numerous.

This book compares very favorably with the other recently published text-books on pathology but is not as large and thorough as some.—E. L. T.

The Conquest of Disease. By Thurman B. Rice, M.D., Assistant Professor of Sanitary Science, Indiana University School of Medicine, and former State Health Commissioner of Indiana (The Macmillan Co., New

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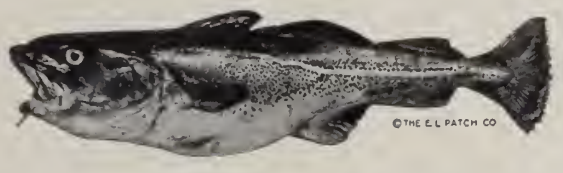

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York), is one of the first of the 1927 contributions to the literature of disease control. The author announces three purposes: (1) To set forth the more recent scientific information, (2) to make it interesting, (3) to emphasize the advances that have been made and to create confidence in the science of disease prevention.

The book has an interesting vein of happy optimism without losing sight of the fact that we have not reached the ultimate goal. The first object of the author to set forth the most recent scientific information has certainly been attained. The second object, to make it interesting, is perhaps best illustrated by the fact that this reviewer to whom these scientific facts were not new read the book with interest and enjoyment in one day. The use of paragraph captions is particularly good. Frequently the author strikes the keynote of a whole chapter in five or six words such as "the truth shall make you free," and "take the 'sigh' out of science," "the clenched fist supplants the folded hands," "the slaughter of the innocents," "there is death in the pot," "laziness is a germ disease," "have you had your chill today?"

The charts are simple, clean and easy to read. The circular diagrams illustrating the epidemiology of the various diseases are the best that I have seen. The historical introductions are sufficient and not too lengthy. Best of all when the author says "summary" as he does at the end of each chapter, he really means it. These summaries are brief, snappy, inclusive and in some instances are as short as two or three lines. They tell the whole story.

On the other hand it seems to me that he is unduly optimistic about the prevention of scarlet fever and the value of the Dick and Dochez sera. He makes what I regard as an unfortunate statement when he says that tuberculosis sanatorium beds are neither available for the so-called middle class of people nor necessary, except as they are used for a short training period in how to live. It is unfortunately all too true that he is correct about the lack of sufficient beds, but I cannot agree with him that a short training period in how to live is all the sanatorium treatment a tuberculous patient requires. The experience of Wisconsin sanatoria alone seems to point in the opposite direction. He emphasizes, however, the curability of early tuberculosis and the fact that any climate is suitable for recovery if the treatment is right.

The author has a unique project for the control of measles. He recognizes the futility of attempting to eliminate it and in fact does not believe it should be eliminated because with measles immunity lost in our civilization we should fall easy prey to its reintroduction and repeat the tragic role of the savage races exposed to it for the first time. He proposes choosing a favorable season when school is closed and pneumonia is not prevalent, exposing all children to measles intentionally and then treating them all with convalescent serum at once, thus assuring a light attack and freedom from complications. While this is excellent theoretically, many practical difficulties inherent in popular psychology seem to stand in the way of its general adoption. It is quite likely that parents would not object to the intentional exposure to measles since many of them practice it themselves. It is the use of convalescence serum to which they would object and that of course is the salient point of the whole plan.

To sum up: This is a readable, brief, authentic and valuable treatment of the subject. Physicians and nurses ought to read it and it would be an excellent book for the library of the intelligent layman.

—W. W. B.

Modern Practice of Pediatrics. By William Palmer Lucas, M.D., Prof. of Pediatrics, University of California Medical School. Price $8.50. The Macmillan Company, New York.

Dr. Lucas has written a well-balanced and complete text-book covering the entire range of pediatrics, and incorporating the latest advances in this specialty. There are a number of excellent text-books already published and a still larger number of mediocre and poor ones, but Dr. Lucas' book belongs to the first class. A very fine feature of this work is a list of reference readings at the end of each chapter. There the student or physician may find the references to the writings of the authorities mentioned in the text. There is also a very valuable chapter on therapeutic and diagnostic procedures which cannot fail to be of great assistance to the practitioner. The chapter on accidents is likewise instructive and interesting. There are many other unusual features in this book and it is the unusual features rather than the ordinary topics always found in pediatric text-books that gives this volume its merit. As a complete one-volume work it can be heartily recommended to students and practitioners.—R. M. G.

Medical Clinics of North America. Volume IX, Number V, Chicago number, March, 1926. Octavo of 206 pages with 34 illustrations. Per clinic year, July, 1925, to May, 1926: Paper, $12.00; cloth, $16.00, net. W. B. Saunders Company, Philadelphia and London.

The Chicago number of the Medical Clinics of North America is always welcomed with pleasure. One of the most interesting contributions is that from the clinic of Dr. Walter Hambarge. In a series of carefully worked up cases he describes the acute lesions of the coronary arteries which are so often labeled "acute indigestion." The frequency of fullness, sense of pressure, belching, nausea, vomiting, and pain in the upper abdomen receives timely consideration. The negative T wave is the final argument in favor of coronary disease and its persistence may lead to unfavorable prognosis.

Drs. Abt and Straus draw some interesting conclusions from a series of 221 cases of hypertrophic pyloric stenosis in which a modified Rammstedt operation was performed. They note that this condition occurs more commonly in the male child and appears between the third and fifth weeks of life.

They also believe that the mortality is reduced by preoperative glucose and saline intravenously. The modified Rammstedt with flap was proven most satisfactory in their experience.

Tuberculous lobar pneumonia is a much more com-

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Cutaneous Manifestations of Allergy*

BY O. H. FOERSTER, M.D.
Milwaukee

The term anaphylaxis was introduced by Richet in 1902 to denote certain phenomena induced in animals following a second injection of substances which were harmless upon their first injection. This term is the direct antithesis of prophylaxis, and designates a condition in which there is a specifically decreased state of defense or diminished immunity. Immune processes of the body are commonly interactions of substances of protein nature, antigen and antibody, and though anaphylaxis is a self-destructive reaction most immunologists are agreed that it also is a true antigen-antibody reaction. Further experimental and clinical observations in this new field disclosed the occurrence of reactions similar to anaphylaxis in which proteins apparently are not concerned.

In 1906 the term allergy was introduced by von Pirquet to denote the altered reactivity developed in the organism following disease and occurring after preparatory introduction of bacterial products and other substances foreign to the organism. This concept of allergy is one having considerable latitude and includes not only anaphylaxis but all non-protein reactions as well. The change in reactive ability, or allergy, can manifest itself according to von Pirquet as an increase or decrease in rapidity of onset of reaction (immediately after the second introduction of the agent foreign to the body, within 24 hours, or after several days), or as a quantitative alteration in the degree of the reaction (increased reactivity-hypersensitiveness, anaphylaxis; diminished or checked-decreased sensitiveness, immunity), or as a qualitative alteration in the nature of the reaction or of the reacting tissue.

Such criticism as was directed toward von Pirquet's conception of allergy, was concerned chiefly with limiting its scope of application, and the discussions have continued to this day. Most students in this field are now agreed in considering allergy as "a condition of unusual or exaggerated specific susceptibility to a substance which is harmless in similar amounts for the majority of members of the same species. The exciting substance may or may not be primarily a protein and may or may not engender the production of *free* antibodies demonstrable in the serum" (Kolmer). The state of allergy would therefore include both hypersensitiveness, in which the exciting agents are non-protein substances, and anaphylaxis in which the exciting agents are proteins or their derivatives. The disturbed mechanism underlying the various manifestations of allergy in man remains unknown, though it is believed to be a cellular reaction and probably a phenomenon of colloidal chemistry.

Most of the earlier research was on anaphylactic sensitization of guinea-pigs with horse-serum, in connection with the subject of serum therapy, and later this led to a closer study of hypersensitiveness in man, especially in relation to the tuberculin reaction and to food and drug idiosyncrasies. It was soon recognized that the subject of hypersensitiveness "is one of great importance in man in relation to disease and immunity, serum, vaccine- and chemo-therapy, and the various idiosyncrasies to foods, drugs, and other substances."

Hypersensitiveness to various substances is a factor of first importance in the etiology of many diseases in man, including a number of dermatoses. It has been stated that hypersensitiveness in man with clinical manifestations occurs in ten per cent of individuals in general. A predisposition to hypersensitiveness is often inherited and Duke states that "specific hypersensitiveness is one of the most consistently hereditary of diseases." In a series of 500 cases of sensitization Cook and Vander Veer found that almost half showed sensitization in the antecedents. They also found that if both parents were hypersensitive, the sensitized or allergic state was manifested earlier in the children than when only one parent was allergic, and furthermore that children of such parents

*Presented before 85th Annual Meeting, State Medical Society of Wisconsin, Madison, Sept., 1926.

often develop hypersensitiveness to substances that are different from those to which the parents are sensitized.

The symptoms and pathologic changes of allergy as observed in humans are quite varied. The common manifestation of anaphylaxis in man is either syncope immediately following the intravenous injection of serum, or the development of serum sickness characterized by fever, joint pains, lymphadenitis, and a more or less extensive urticarial eruption. Acute fatal anaphylaxis following the administration of horse-serum has occurred, though rarely, and usually in those extremely sensitive to horse proteins. Allergy to the effluvia of animals, as the dandruff of cattle, horses and cats, and to pollens, usually exhibits itself by coryza, sneezing, vasomotor rhinitis, lacrimation, and less often by various grades of dermatitis. Allergy to foods and drugs may manifest itself in an acute form by sudden swelling of the lips, oral mucosa and tongue, by vomiting, diarrhea, and intestinal colic, or in a chronic form in which the skin alone is involved by urticarial and eczematous eruptions. In all of these manifestations of allergy the basic condition is a vasomotor paresis with vascular dilatation and serous exudation.

ALLERGY TO SERUM

The term serum sickness was introduced by von Pirquet and Schick to designate the symptoms observed in man following the injection and reinjection of horse-serum. In most instances the reaction following the first injection is delayed until after four to twelve days. Rarely an immediate reaction occurs following the first injection in individuals extremely sensitive to horse-serum. More frequently a reaction occurs within a few minutes to forty-eight hours after a second injection when the first has been given within a few months. When an interval of a year or more has elapsed between injections the reaction occurs in from four to seven days. As a rule the symptoms are mild and recovery is rapid. In naturally hypersensitive individuals or those who have been sensitized through previous injection, preliminary desensitization may be employed; but horse-serum should never be given to any person who exhibits an undue hypersensitiveness manifested by asthmatic or hay-fever attacks when he is exposed to the effluvia from horses (Kolmer).

The usual reaction constituting serum disease is manifested by an eruption, fever, diarrhea, prostration, muscle and joint pains, edema of the face or extremities, and usually regional adenitis. The majority of serum eruptions appear between the sixth to the ninth day after the injection of antitoxin, though they may occur on the first day or as late as thirty days. In the order of their frequency the eruptions are urticarial, multiform, erythematous, scarlatiniform, morbilliform, vesicular, bullous, and purpuric. In from seventy to ninety per cent of cases the eruption is urticarial or an urticarial erythema, accompanied by intense itching. Multiform types are common. The eruption is most apt to appear first about the site of injection, often within twenty-four hours, it then disappears, and reappears later as a general exanthem. Any area of the skin may be involved, though the sites of predilection are the extremities and trunk. The duration is from two to five days, and the eruption may recur even after several weeks.

ALLERGY TO DRUGS

Allergy to drugs is common. It is a condition in which an amount, often minute, of a substance innocuous for most individuals produces an unusual and characteristic reaction. Drug allergies are highly specific and the specificity is often attached to a definite element or chemical group. In hypersensitiveness to compounds of mercury the active part is the element mercury; in iodoform allergy the methyl group rather than the iodid or iodin is apparently the specific part.

The characteristic symptom of drug allergy is the cutaneous eruption. But it should be emphasized that all drug eruptions are not manifestations of allergy; a certain number may be due to excessive cutaneous elimination and other factors. Thus, the study by Wile, Wright and Smith of bromid and iodid eruptions indicates that the explanation of their production lies in a complex biochemical reaction rather than in a sensitization phenomenon.

The number of drugs capable of producing reactions in allergic persons is extensive. The list includes alkaloids from opium, cinchona, belladonna, and other plants, balsams, resins, turpentine, various metals such as mercury and notably arsenic, including the arsphenamins; also coal-tar and other derivatives as antipyrin, iodoform, salol, salicylic acid, creosote, aspirin, and the like.

The analogy of drug reactions to serum reactions is often striking. While allergy to drugs may be present in young children, authentic in-

stances of an inherited allergy to drugs are rare, though it is probable that a tendency to acquire hypersensitiveness to drugs is inheritable. Drug allergy is usually a permanent condition though a certain amount of toleration can sometimes be established by using small dosages.

In most instances the symptoms of drug allergy are manifested within a few minutes to a few hours; in highly sensitized subjects they may appear with startling rapidity as seen especially in the allergy to quinin and formalin and the fixed erythema of arsphenamin as observed in my experience. In some persons the symptoms develop only after repeated administrations of the drug over a period of one to three weeks, as occurs with arsphenamin. A peculiar cutaneous reaction is the fixed pigmented erythema observed with antipyrin, phenacetin, salipyrin, arsphenamin, and more recently recognized as also occurring with phenolphthalein. In this form the eruption occurs always in the same circumscribed areas with each administration of the drug and results in pigmentation of the affected area.

The most common eruption is urticarial or an urticarial erythema as observed in serum sickness, and edema is often present, especially of the face. Or the eruption may be papular, vesicular, hemorrhagic, or a combination of these; in fact, practically all of the lesions that can occur in the skin may be produced by drugs. Fever is a frequent symptom and may rise as high as 105 degrees, and chills occasionally occur. Joint and muscle pains, swelling of glands, and lowered blood-pressure may also develop, as in serum disease. Individual peculiarities in drug allergy may be encountered, such as erythema and swelling of the prepuce due to antipyrin, balanitis due to quinin, and others.

ANIMAL AND PLANT SUBSTANCES

It is a matter of common observation that certain individuals react to contact with the hair and dandruff of animals, notably of the horse, cattle, rabbit, guinea-pig, goat, and less often the cat, and to the feathers of chickens, ducks, turkeys and geese, as also to a variety of plants, more especially rhus, primrose, and ragweed.

The allergic condition of such individuals when exposed to animal substances is usually expressed as asthma, vasomotor rhinitis, and other hay-fever-like symptoms, and less often as a dermatitis. An extreme degree of sensitization may exist so that mere proximity to the animal suffices to produce an allergic attack. An instance of such extreme sensitization observed by me was that of a young girl living on a farm who had an extensive "eczema" since infancy, which disappeared when she attended school in a neighboring city, and immediately reappeared in its original distribution and violence whenever she returned to her home over the week-end. Although the patient was not in actual contact with cattle on these visits to her home, the contact with members of the family who attended the cattle apparently sufficed to produce the allergic dermatitis. Cutaneous tests with cow dander produced a marked skin reaction, while tests with horse, cat, and dog allergens produced no reaction whatever. This patient did not exhibit symptoms of asthma or vasomotor rhinitis at any time, though it is unusual to have a purely cutaneous reaction when hypersensitiveness to animal substances exists. This is especially true in hypersensitiveness to the horse, asthmatic attacks being present in almost every instance. An exception is that of a young man under my care for a chronic generalized allergic dermatitis in whom an alarming syncopal attack occurred when he rode behind a horse. Kolmer states that "individuals may be hypersensitive to the hair of an animal and not to its serum; as a general rule, however, hypersensitiveness to the horse includes sensitization to hair, dandruff and serum, and for this reason the administration of horse-serum in the prophylaxis and treatment of disease may be very dangerous for such persons."

Dermatitis caused by contact with the hair of a guinea-pig is not unusual, and Markley has recorded a unique instance in which only localized areas of the skin were sensitized and reacted with a dermatitis. I have observed several instances of localized urticarial erythema produced by contact with caterpillar hair. A localized or generalized dermatitis may also be produced by contact with wool or mohair (goat-hair), and silk may likewise produce an allergic dermatitis.

In allergy to animal substances the diagnosis is sometimes readily made, as the patient often has already established the causal connection. When cutaneous symptoms alone are present the allergic nature may not be quite as apparent, but careful inquiry into the history for possible animal contacts, and the results of skin tests may establish the diagnosis. In this type of allergy skin tests appear to possess some diagnostic value. In cases

of recent development the dermatitis is frequently limited to the face and the dorsum of the hands, though the flexures at the elbows and the popliteal regions are often affected. The eruption often occurs in diffuse, not sharply marginated patches and is composed of small papules on an erythematous and often edematous base, frequently with abortive vesiculation, and an exudative tendency. Crust-covered excoriations from scratching are common as the eruption is often attended by intense itching and burning sensations. As the dermatitis subsides scaling is a prominent feature, and after repeated recurrences the involved skin becomes infiltrated and leathery. In chronic forms the infiltration is most prominent, the skin is thickened and its folds are exaggerated, fissures develop, patches of exudation appear from time to time and the patient is tormented by spells of the most intense itching. Eventually a large portion of the cutaneous surface may be involved, though the eruption is more often limited to the face, neck, and arms even in cases of long duration.

Local applications provide only temporary relief, and it is essential to establish the etiologic factor and to eliminate this before permanent relief can be secured.

Dermatitis due to plant substances is exhibited by only a small proportion of persons coming in contact with the various kinds of rhus (ivy, sumach and oak), primrose and other plants, but the extreme sensitiveness of some individuals strongly suggests that they have been sensitized to the specific irritant. Sensitization may not develop for some time and only become evident after years of contact, when a dermatitis suddenly appears and the skin thereafter remains hypersensitive for an indefinite time. This is not an unusual experience of florists and housewives in connection with the primrose, which they often handle with impunity for years only to suddenly develop an extreme hypersensitiveness. I have seen a number of such instances in which the acquired sensitization to primrose developed late, and the same is true of rhus toxicodendron or poison ivy. The juices of these plants contain irritants capable of producing dermatitis by direct contact and without allergic sensitization, but the fact that only certain individuals are susceptible and some to an extreme degree, suggests that allergies to these plants may develop. The active principle of poison ivy is toxicodendrol and that of poison oak is lobinol, both non-volatile oils, and they are held responsible as the exciting agents in producing rhus dermatitis. The active principle of the primrose was found by Simpson of Washington to be soluble in absolute ethyl alcohol, whereas the protein was inactive. Many investigators do not believe that dermatitis venenata is an allergic phenomenon but consider tolerance to be dependent upon non-specific variable factors related to the structure of the sweat and oil glands and the chemical nature of their secretions. The reports by competent observers of the successful use of preparations of extracts of poison ivy as antigens, given by mouth and intramuscularly by injection, in the treatment and in desensitizing of cases of dermatitis due to ivy, have been held as further evidence of the allergic nature of the dermatitis. Similar good results are recorded in dermatitis due to poison oak. However, Weidman and Krause in a series of carefully controlled tests on human subjects were unable to ascribe any value to this method either as a desensitizing or curative measure. Our experience with this method of treatment in ivy poisoning has been limited and thus far is not conclusive.

Dermatitis due to rhus vernicefera, the lacquer plant of Japan and China, has been observed recently in this country following contact with lacquered objects, such as Japanese boxes, canes, bracelets, and more especially mah jong tiles and boxes, the symptoms being practically identical with those observed in cases of ivy poisoning. In a recent instance of such dermatitis due to the wearing of a bracelet of lacquer, Williams treated the patient successfully with injections of rhus toxicodendron antigen, and is of the belief that this antigen may be useful in any form of rhus poisoning.

In ragweed dermatitis Sutton used injections of an extract of ragweed pollen in gradually increasing dosage and succeeded in desensitizing the patient. Reports on this subject are so much at variance that desensitization by these methods must still be regarded as an unsettled question.

The list of plants and vegetable substances which are capable of producing dermatitis is lengthy and they need not be enumerated here. Similarly, numerous chemical irritants such as those contained in dyed furs, in hair dyes, cosmetics, toilet preparations, perfumes, tooth pastes, and the like, produce dermatitis in certain individuals and not in others. The list is almost endless and to incriminate any particular one of them

in the individual case is often a matter requiring detective-like instincts. I will only mention the case of Oliver's patient whose dermatitis of the face, which recurred regularly every Monday morning, was eventually determined to be due to a constituent of the ink used in printing the rotogravure section of a Sunday morning newspaper. Some of these dermatoses appear to be actual examples of allergy while others are explainable on other grounds.

FOODS

Allergy to certain foods has been known clinically for many years and is relatively common. It is only recently, however, that this subject has received more careful study, chiefly by pediatricians and dermatologists, who have demonstrated the allergic nature of one kind of asthma in children, and the occurrence of various dermatoses, notably eczema and urticaria, as often due to food allergy.

Sensitization to foods is most often acquired, although it is believed that a predisposition to sensitization may be inherited. It appears as though nursing infants may become sensitized to food substances eaten by the mother which pass to them in her milk. O'Keefe obtained skin reactions in nursing infants to proteins they had never eaten, and Shannon observed that the elimination of certain foods from the diet of a mother who was hypersensitive to these foods, was followed by the disappearance of an urticarial eruption in her nursing infant. Infants and children frequently exhibit food allergies, and particularly in infants, inflammatory changes in the enteric mucosa aid in sensitization by facilitating the absorption of the sensitizing protein bodies. Kolmer states that since proteins digested to the peptone or amino-acid stages are doubtfully allergenic, it is probable that sensitization can result only from the absorption of undigested or partially digested foods. Hettwer and Kriz have recently confirmed these clinical observations by a series of experiments on guinea-pigs in which they caused absorption of unchanged protein from the ligated intestine with the production of anaphylactic symptoms.

According to Duke, foods that sensitize may be protein, non-protein, organic or inorganic. The foods most commonly producing allergy in adults are buckwheat, pork, cheese, various sea foods, strawberries and gooseberries, and almost every common food has occasionally been implicated. In young children foods most often responsible for sensitization are cow's milk, eggs, oatmeal, potato, rice, peas, wheat, beef juice and chicken. Schloss has shown that the food allergy may be cyclic. Usually sensitization is multiple, that is, it exists to several foods, but it may be limited to a single substance.

The symptoms of food allergy may occur in the alimentary or respiratory systems or in the skin, either confined to one system or in combination. The association of bronchial asthma and eczema is often observed, one disorder alternating with the other at irregular intervals. Edema of the lips and tongue is frequent, and the edema may involve the pharynx and larynx in extreme cases. Buckwheat or egg are often the responsible agents in this type. Urticaria occurs with great frequency; the angioneurotic edema sometimes observed is a giant urticaria. Erythema multiforme and dermatitis are examples of the more chronic manifestations of food allergy.

The eczema, or preferably the allergic dermatitis, observed in infants, requires a special word. Recent investigations of the proteins by Blackfan, Schloss, O'Keefe, Walker, Engman and others, have shown a high percentage (from 40 to 80 per cent) of protein sensitization in infantile eczema as determined by the cutaneous sensitization test. This is significant when contrasted with a negligible incidence of protein sensitization as observed in normal children and reported by Baker. Removal of the offending substance from the diet has resulted in the disappearance of symptoms in from 20 to 70 per cent, and in addition produced improvement in from 15 to 60 per cent. It appears established that in a considerable proportion of the eczemas of infants the condition is an allergic dermatitis having its cause in a protein sensitization.

In the eczema of adults the situation is less clear with respect to the significance to be attached to the cutaneous tests. The reports are varied and the results of treatment based on the interpretation made of the tests are uncertain and unsatisfactory. A careful history in these cases appears to us to have a greater value. In the urticarias more reliance can be placed on the cutaneous tests as checked by the clinical results.

I am in accord with Ormsby* when he states that the cutaneous food tests are valuable aids but have strict limitations and recommends them only in selected cases. Longcope and others have shown

that positive tests are often obtained in individuals who exhibit no symptoms. It is also known that a positive test does not necessarily mean that the symptoms present are due to the particular agent giving the reaction. The interpretation is therefore not a simple matter, but requires consideration of all the facts to be elicited from a careful history, physical examination, and close observation of the patient. It is also possible that some of our indifferent results with the cutaneous tests, especially with the food allergens, may be due in part to the use of non-potent materials. In any event the subject of protein skin reactions and their significance requires further study to determine its actual degree of efficiency.

BACTERIA

Allergy to bacteria as observed in dermatology is confined to the development in the skin of the comparatively rare lesions known as tuberculids and leprids; a factor in their production is the local destruction in the already sensitized skin of, respectively, the tubercle and lepra bacilli. A similar condition appears to occur in the production of sarcoids, also of tuberculous origin. There is reason to believe that the relatively common condition known as infectious eczematoid dermatitis is an allergic cutaneous reaction of the nature of an acquired sensitization to the staphylococcus group. The originally local sensitization to bacteria appears to be capable in some instances of expansion into a general sensitization of the skin. The ringworm fungus also is responsible for an allergic state induced in the skin resulting in an eruption termed tricophytid. This has been recognized only recently, is not often observed, and occurs chiefly in association with the kerion type of infection of the scalp. All of these allergic phenomena appear to be protective reactions.

PHYSICAL AGENTS

Allergy to physical agents has recently been intensively studied by Duke of Kansas City, who considers allergy of this type to be closely related to though not identical with allergy caused by material substances (proteins). He has observed individuals with symptoms of bronchial asthma, conjunctivitis and vasomotor rhinitis, photophobia, abdominal pain, pruritus, erythema, urticaria, angioneurotic edema, eczema and shock occurring in varied combination, apparently caused by light, heat, cold, mechanical irritation, freezing and burns. The reactions were found to be either limited to the area of contact or more widespread in their distribution. Duke's investigations have shown a marked similarity between some of these reactions to physical agents and pollen reactions, and his work appears to have opened for research an entirely new field having important clinical relationships.

SUMMARY

This summary of the important phase of immunology under which the allergic reactions are included, has been presented with special reference to its dermatologic aspects. It is evident that at the present time our knowledge of the subject, both experimental and clinical, is only fragmentary, although clinical medicine in all of its branches already has been much enriched by the researches of the past twenty years. This field of research is not barren but offers further rich rewards to the investigator, and for this purpose it is commended to the clinician and to the experimenter in the laboratory.

*Ormsby (Jour. of the South. Med. Assoc., Dec., 1925) has presented a valuable summary of allergy in dermatology, which the writer has consulted freely in the preparation of this article.

Pollenosis*

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The early contributors to the study of pollenosis or hay-fever were physicians of the old English School. In 1819, Bostock recognized the disease as a definite clinical entity. He then gave an account of "A Case of Periodical Affection of the Eyes and Chest."[1] In 1833, Elliotson suggested but was unable to prove the cause of the disorder. "The disease," he stated, "depends upon the flower of the grass, and probably upon the pollen." In 1865, Blackley first proved that the pollen of the grasses was responsible for the English type of hay-fever.[2]

In this country, Morrill Wyman,[3] in 1872, made

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a noteworthy study of the autumnal form of the disease. He favored the pollen theory. In 1875, Marsh shared the same view as did Wyman and believed that autumnal catarrh was caused by the "presence of pollen of flowering plants in the atmosphere."

The German school, represented by Dunbar[4] and his pupils, Weichhardt, Pransnitz, and Kammann, accepted the pollen theory which had been advocated by the English and American schools as the cause of hay-fever. Their work placed our present-day knowledge of the disease on a firm scientific basis. In 1902, Dunbar demonstrated that the protein constituent of the pollen grain was the active agent.

The earlier writers, notably Blackley and Wyman, called attention to the occurrence of hay-fever among the educated classes. Blackley even designated hay-fever as an aristocratic disease. The present-day prevalence of the disease among our artisans testifies to the changing character of aristocracy with the changing times.

Hay-fever merits the serious consideration of the medical profession of the United States because of its greater prevalence in this country than on the European continent. According to the record of the American Hay-Fever Association the number of hay-fever cases in the United States is about 1,050,000 or about one per cent of the total population.[5] Applying this percentage to the population of the District of Columbia for the calendar year 1924, it appears that there are approximately 4,869 victims of the disease in the national capital. The total number of reportable diseases in the District of Columbia for 1924 has been 5,827—an increase over the hay-fever total by only 958. Furthermore, a study of the annual report of the health officer for the same year indicates that the number of hay-fever cases exceeds by more than 3,000 the number of the reported cases of any one of the more prevalent diseases—such as chickenpox, scarlet fever, or the communicable forms of tuberculosis.[6]

The like prevalence of the disease in other communities emphasizes its importance from a public health point of view. Moreover, its hereditary tendency assures a progressive increase in the ranks of hay-fever victims. Experience has taught only too well that a definite proportion of children in hay-fever families sooner or later are added to the total of clinical cases. The elaborate studies of Cooke and Vander Veer[7] have confirmed the earlier observations regarding the hereditary tendency of hay-fever. The transmission of sensitization as a dominant characteristic from parent to offspring in accordance with the Mendelian law has been suggested by their analysis.

The variety of pollen to which the patient is sensitive determines the type and duration of the disease. The spring type, which begins in March and ends in June, is coincident with the pollination of the trees; the summer type, caused by the pollen of the grasses, or the plantains, runs its course from May to the middle of July; and the autumnal type, due to ragweed in the eastern United States, begins in the latter part of August and usually terminates with the first frost. There are also patients who are sensitive to both the pollens of the grasses and of the ragweed. Their season is, therefore, prolonged. A few unfortunates, who are in addition sensitive to the pollen of trees, may suffer from symptoms from early April to November.

Curiously enough, there are some patients whose period of distress extends beyond the period of active pollination of the offending plant. It seems as if the vasomotor mechanism has been disarranged by the protein poison. As a result, there is a peculiar irritability; and hay-fever or asthmatic symptoms may ensue upon exposure to drafts, changes of temperature, odors, or dust out of season. Susceptibility to winter "colds," with or without asthma, is another expression of vasomotor disturbance.

In many instances, the hay-fever season is followed by a long convalescence, which lengthens the period of impaired efficiency. The economic importance of hay-fever becomes obvious. This fact has not been fully appreciated by industry.

SYMPTOMS

The symptoms of hay-fever are referable to the skin, eyes, ears, nose and throat. Not only does the severity of symptoms vary in different individuals, but also the degree to which each of the organs is affected. Itching of the scalp or itching of the skin over other parts of the body may usher in the disorder. This is accompanied by a tickling and itching of the lining membrane of the nose which extends to the eyes and even into them. Sneezing, in paroxysms, inevitably follows the nasal irritation. The rising hours usually mark the period of attacks of sneezing, due in part to change of position and in part due to a cooling of the body surface. Attacks of sneezing may be

provoked by dust, by draughts, or by change from shade to sunshine. The watery discharge from the nose requiring the daily use of two or three dozen handkerchiefs by some patients is equally distressing. The sensation of fullness in the nostrils gives rise to a sense of suffocation which necessitates mouth breathing.

The eyes are subject to a similar course of discomfort. Itching of the eyeball and eyelids, aggravated by rubbing, brings on a copious flow of tears. The eyelids may become so swollen as to obscure vision; and the irritation so intense as to make the eyes extremely sensitive to light. The itching of the nose and eyes extends to the roof of the mouth, to the posterior nares, and through the Eustachian tubes into the ears. The itching of the ears is intolerable. Cough is an inconstant symptom of hay-fever. When it occurs, it is the cough of irritation due to a tickling sensation within the trachea.

Asthma, the most dreaded complication, comes early in the course of some patients, and late in others. It made its appearance in seventy-two per cent of our cases.

It is noteworthy that the skin, eyes, ears, and upper respiratory tract, the organs most exposed and most accessible to environmental agents, are the organs affected. Blackley has attempted to explain the symptoms of hay-fever on both a mechanical and physiological basis. He believed that the favorable conditions of warmth and moisture in the nasal and oral cavities encouraged the development of pollen tubes. The extension of these pollen tubes along the surface of mucous membranes and possibly their penetration into mucous follicles produced signs and symptoms of irritation. Moreover, the expulsion of the granular contents of the pollen grains into the submucous cellular tissues resulted in an effusion of fluid and the consequent feeling of engorgement of parts affected. Subsequently, the passage of the granular matter of the pollen by dialysis from mucous membrane into the circulation gave rise to constitutional symptoms.

There is ample clinical evidence in support of the intoxicating effects of dissolved pollen granules or pollen protein, as it were, upon the susceptible individual. In the course of intracutaneous testing or of desensitizing treatment with solutions of pollen protein, symptoms of hay-fever or of asthma may suddenly arise, even though the subject has in no way been exposed to the inhalation of pollen dust.

The diagnosis of hay-fever is suggested by the seasonal occurrence of the symptoms which have been discussed and is confirmed by cutaneous tests with pollen. The itching of mucous membranes is especially characteristic of pollenosis. It helps to distinguish the disease from the ordinary "cold." The average hay-fever subject can readily differentiate between the sneezing of his affliction and the sneezing of infection by the presence or absence of itching.

CUTANEOUS TEST

The cutaneous test, first described by Blackley in 1865, has proved a valuable diagnostic aid in determining the plant responsible for symptoms. A series of superficial scratches is usually made on the forearm with a needle, and to each abrasion a slight amount of pollen is applied by means of the flattened end of a toothpick. The pollen is moistened with a drop of decinormal sodium hydrate to assist in the solution of the pollen protein. Within half an hour, a characteristic wheal, such as is seen in urticaria, appears at the site of the abrasion to which the offending pollen has been applied. A zone of redness surrounds the wheal. There may also be more or less itching of the skin of the forearm. A positive skin reaction indicates that the patient is sensitive to that particular pollen which produces the wheal. The pollens to which the patient is non-sensitive will not cause skin reactions.

The formation of an urticarial wheal represents an effusion of serum within the superficial layer of epithelial cells. It is the tissue response provoked by the presence of an irritant. It is assumed that the skin, in common with the blood and tissues, contains a specific proteolytic ferment which liberates from the protein molecule of the pollen a poisonous end product. It is the latter which causes the inflammatory reaction in susceptible individuals.

This process is identical with the one which takes place on the mucous membranes of the conjuctivae, of the nose, and of the mouth. The presence of proteolytic enzymes leads to a parenteral digestion of pollen protein. The cleavage products of such digestion give rise to local symptoms and, on absorption, to constitutional symptoms.

There are a few considerations which should guide cutaneous testing with pollens. A knowl-

edge of the local flora and of flowering dates is essential. Such information should be made available to the members of the profession. Hitherto, botanic surveys have been largely the result of individual effort. "The Hay-fever Plants of California," by Hall,[8] "A Botanic Survey of Kansas City, Mo., and Neighboring Rural Districts," by Duke and Durham,[9] "The Botany of Southwest Texas, with Reference to Hay-Fever and Asthma," by Kahn,[10] are noteworthy records of useful information. The more recent report of the Hay-Fever Research Committee of the State Historical and Natural History Society of Colorado by Waring[11] illustrates the advantages of organized effort. The example of Colorado is worthy of emulation by other state organizations. I have published a partial list of the Hay-Fever plants of the District of Columbia.[12] Thanks to the cooperation of Drs. B. T. Galloway and W. W. Stockberger of the U. S. Department of Agriculture, this list is being extended and specimens of pollen are being preserved for museum purposes. With an interest equal to that of the bacteriologist in his "stock cultures," the immunologist will guard the specimens of pollens of his territory. He will point to them with pride and scratch with success.

In this connection, only the wind pollinated plants need be regarded as possible offenders. Their blooms are inconspicuous and have neither bright color nor scent. The amount of pollen they produce is surprisingly large in order to insure fertilization and guard against the many chances for failure.

The opposite holds true of insect pollinated plants. They have conspicuous or brightly colored blooms, which are provided with honey glands. Their pollen grains are large and surrounded with a sticky envelope. There is scarcely enough of them floating in the air to excite symptoms. The fundamental principle that hay-fever plants are wind pollinated excludes from consideration the roses, goldenrod, sunflower, daisy, dandelion, and all of the common fruit trees. The popular fallacy that roses and goldenrod are causes of hay-fever still has a strong hold on the imagination, and the continued exploitation of their pollen extracts in the prevention of hay-fever is unwarranted.

Further studies have disclosed a tendency among hay-fever subjects to give positive skin reaction to many pollens. In fact, the impression that multiple sensitization is the rule and not the exception has been confirmed by many workers. Thus, it has been observed that the vernal cases react to the pollens of many grasses and that the autumnal cases react not only to the pollen of the ragweed but also to the pollens of the goldenrod, daisy, goldenglow, and sunflower. Such reactions have been designated "group reactions." They indicate that the pollens of closely allied families of plants have in common a characteristic structural arrangement of the protein molecule. It is the latter which gives rise to the skin reaction. A striking example of group reaction has been furnished by the positive skin reactions which I have obtained in autumnal hay-fever subjects with the pollen of Tithonia—an insect pollinated representative of the Compositae of South America to which our patients may never be exposed.

The "accessory reaction" is a term I have applied to the positive skin reaction which apparently has no clinical significance. I have obtained positive skin reactions with the pollens of trees, grasses, and chenopods in autumnal hay-fever subjects. These reactions emphasize the discrepancy between cutaneous sensitiveness and mucous membrane sensitiveness. The patients were free from the usual symptoms of hay-fever even though the above mentioned pollens were in the air. Only exposure to the ragweed pollen excited symptoms of distress.

Any discussion of methods of testing hay-fever subjects for pollen sensitiveness is incomplete if it fails to include the intracutaneous or injection method. This method has been advocated by Cooke in 1911 and has since then been employed by his pupils. The method consists of the intracutaneous injection of about 0.01 cc. of a solution of pollen protein.

A study[13] of the multiple skin reactions in hay-fever subjects has led me to the following conclusions:

"Cutaneous and intracutaneous and mucous membrane sensitiveness to pollen protein are three distinct entities.

"Cutaneous sensitiveness may be present in individuals who do not exhibit mucous membrane sensitiveness to the same pollen.

"The subcutaneous reaction to pollen protein is a more critical and specific index of mucous membrane sensitiveness than the cutaneous or intracutaneous tests.

"The practice of desensitizing individuals with as many pollen extracts as yield positive cutaneous reactions is as unnecessary as it is unwarranted."

TREATMENT

The chief aim in treatment is to bring the patient to a point of tolerating the toxic material which gains entry through the respiratory tract. Desensitization against the specific excitant is likely to assure the patient freedom from symptoms. The credit belongs to Noon and Freeman for devising the method in vogue at present. A series of subcutaneous injections with solutions of protein, prepared from the toxic pollen, is administered at regular intervals with gradually increasing concentrations. The treatment, theoretically, should be preseasonal and terminate with the approach of the hay-fever season.

In general, the course of prophylactic inoculations comprises 15 to 20 treatments. The initial dose consists of five pollen units which is gradually increased to the terminal dose of 1600 pollen units. The pollen unit is an arbitrary, though convenient standard, there being one million pollen units in one gram of pollen. The rules governing the preventive treatments cannot, of necessity, be hard and fast because of the great variation in sensitiveness which exists among hay-fever subjects. Treatments may be safely renewed when the local subcutaneous reaction of the previous dose has disappeared. Increase in dosage may be made when no severe local or constitutional reaction has followed the previous injection. By way of illustration, I may state that I have repeated the initial dose of five pollen units five times in one individual, before proceeding to the administration of the second dose of ten pollen units. Moreover, one other patient proved so sensitive that the dose of two hundred and twenty pollen units marked the termination of her preventive course. Yet her relief from hay-fever symptoms was almost complete.

The specific treatment of hay-fever during the attack offers welcome relief. Seasonal therapy, as recommended by Vaughan,[14] consists of the daily subcutaneous injections of small doses of pollen extract. The administrations may be made daily for ten days, and then at gradually increasing intervals. It is not at all uncommon to have the patient report definite amelioration of symptoms within the first twenty-four hours. The explanation of the mechanism of this form of treatment is given by Vaughan as follows: "During the pollen season," he states, "the nasal mucosa is bearing the brunt of the allergic reaction. The administration of pollen elsewhere, as through the skin, would theoretically distribute the reaction throughout the other tissues, thereby relieving to some extent the intensity of the local reaction."

The results achieved in the prevention of hay-fever are improving with time and experience. Noon and Freeman reported,[15] in 1914, complete relief in 30 per cent, and no improvement in 11 per cent of their series of eighty-four vernal cases. I have also analyzed the results obtained by six groups of American investigators in the prophylactic treatment of 2,684 victims of the autumnal type of hay-fever from 1914 to 1920. I have found that 12.8 per cent have had complete relief and 16.5 per cent have failed to receive any benefit. The remaining 70.7 per cent enjoyed varying degrees of improvement.

The results of the past few years have shown gratifying progress. For the season of 1923, of 89 autumnal hay-fever patients receiving preventive treatment from me, 40.4 per cent were practically free of symptoms; 33.7 per cent were relieved of symptoms to the extent of 75 per cent; 20.2 per cent were relieved of symptoms varying from 25 to 50 per cent; and only 5.6 per cent of the cases were unimproved. The control and elimination of pollen asthma through active desensitization has proven a great boon to the vast army of sufferers. The treatment is as specific as it is efficacious.

The varying and ofttimes disappointing results of the profession at large has been due to the various pollen extracts employed. In 1923, the report of a study of the relative potency of six commercial pollen extracts was published.[16] Only one preparation possessed a potency equal to the control extract, as determined by comparative cutaneous testing. From my own observation and experience I am of the opinion that a glycerolated extract is likely to yield better therapeutic results. As a preserver of potency of pollen extract, glycerol surpasses alcohol. My method for extracting pollen protein is a modification of Coca's method. According to Armstrong and Harrison,[17] the method yields a "stable, potent, specific, bacteria-resisting" product.

In the critical analysis of the results of hay-fever therapy, which after all is our chief concern, the causes of failure assume a commanding interest. Rackemann has collected the data of four large hay-fever clinics, and records the percentage of poor therapeutic results which vary from twenty-three to thirty-six.[18] Nevertheless, in the

same clinics, identical treatment of late hay-fever has yielded perfect results in ten to twenty-five per cent of the patients. No explanation has been offered for failure in such a large group of victims. "It is evident," Rackemann believes, "that success in the treatment demands a course of doses of a size and extent which is optimal for the particular patient. What this means so far as the underlying mechanism of hay-fever is concerned, is a problem, the solving of which must wait upon the collection of data of another kind."[19]

The isolation of the proteins of timothy and orchard grass and the study of their relationship to vernal hay-fever by Csonka, Bernton, and Jones seem to aid in the solution of this important problem.[20] Three proteins have been isolated from the pollen of timothy and have been designated respectively Proteose A, Proteose B, and albumin. Cutaneous tests with the protein fractions have been performed in a series of vernal cases and control cases. Patients have been found sensitive to one, to two, or to the three fractions. The majority of cases are sensitive to the proteoses, which are present in the largest amount. Three patients have by cutaneous tests, shown a sensitiveness to the albumin fraction alone which constitutes one-sixth of the total protein content. These three patients have not been benefited by courses of preventive inoculations with the extract of the whole Timothy pollen. Two of the patients have failed to obtain any relief whatsoever in two successive years of pre-seasonal treatment. The conclusion is warranted that the protein extract of the whole pollen, one-sixth of which is albumin, has not contained enough of the latter fraction to effect adequate desensitization in the albumin-sensitive subjects. Moreover, the clinical course of hay-fever has been unusually severe in these three patients. Notwithstanding this fact, asthmatic symptoms have been absent. It will be recalled that asthma appears as a complication in seventy-two per cent of hay-fever victims, and that the majority of our vernal cases have been sensitive to Proteose A. It seems, therefore, that Proteose A is the fraction responsible for asthma in vernal hay-fever either through the indirect action on the central nervous system or through the direct action on bronchial structure.

Father Time, the severest of critics, will determine the relative importance of protein fractions of pollen in the diagnosis and control of hay-fever.

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See page 252 for discussion.

Asthma*

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It would seem that very little that is really definite or illuminating can be said about bronchial asthma at the present time that has not been said before. But it is possible that by emphasizing certain aspects of the subject some points of value may be brought out. It is still a fact that clinical observation and so-called bedside impressions must be our main reliance in confirming or denying the value of conclusions arrived at by research and laboratory methods, and it, therefore, follows that the clinician still has the right and duty to express himself on the theoretical side of this subject, which is my excuse for coming before you. To think clearly on the subject of asthma, in order that diagnosis and treatment may be carried out in accord with some logical plan, the clinician must have knowledge of the physiological processes involved in the condition, and must also be allowed to fill in with reasonable hypothesis those gaps in our present knowledge that would otherwise mar the complete picture. This paper is an attempt to emphasize some of the fundamentals of the condition as I see them.

Asthma is not a disease entity. It is, however, a fairly definite symptom-complex, recognized with little difficulty in most instances because of its definiteness. It is one of the clinical manifestations of a systemic condition, more or less widely distributed throughout the body, to which we give the term hypersensitiveness or sensitivity. The manifestation of this sensitivity we call allergy, or variously anaphylaxis atopy, or some other coined term which had special meanings in the minds of the makers, but which have little more than historical interest now. The third leg of the tripod is the antigen, that is, the excitant of the manifestation of sensitivity.

Asthma, then, is an allergic phenomenon. It is to be associated with hay-fever, urticaria, angioneurotic edema, some of the eczemas, etc.

Grouping, and finally more definite classification, are most important steps in the study of clinical medicine. Largely hypothetical at first, based upon superficial resemblances, the group is added to or subtracted from by the method of trial and failure as the study of the units comprising it brings us nearer to an understanding of the fundamental nature of the phenomena presented. The inclusion of asthma in the group of allergies gives us the opportunity to add to our understanding of it whatever we may learn from the study of simpler forms. But when we try to understand a skin test reaction, which is probably the simplest form of allergy recognized, we realize the fundamental nature of the phenomena presented and recognize that there are gaps in our knowledge of cell physiology.

Now, the basic fact of allergy is hypersensitivity of tissue. Without it there is no allergy. It lies dormant in the individual without indication of its existence until called into activity, for sensitized tissue is not known to be physically different from other tissue. It is true that we know a good many characteristics of sensitivity, that it is inheritable, though not necessarily to perform in the same clinical form, that commonly it is made manifest by excitants of the proteid group, that it is exhaustible at least with the same amount of excitant in a given tissue for a certain length of time, and that it can be produced experimentally in certain instances and forms. But we do not understand this abnormal function itself.

There is a phenomenon which I cannot help thinking sheds some light on sensitivity. In routine skin testing many individuals are found who react to food antigens quite typically who, however, present very slight or no allergic disturbances, and who do not even later develop the more marked types of allergy, in other words, do not become clinically allergic. It is seen most commonly and clearly in infants and children. At different times they give positive reactions to different foods, losing the ability to react to certain foods and acquiring the ability to react to other foods, and it becomes possible to convince oneself after many of these observations that there is a tendency, which amounts almost to a certainty, that as each new food is added to the dietary, the time comes when the individual will become reactible to that food, or rather class of foods; and that later in most instances this reactibility will be lost. This seems to be a normal

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phenomenon, unaccompanied by any symptoms that can be called allergic or by such slight symptoms as to present no clinical significance. The same phenomenon is seen in adults though less frequently, and seems to be paralleled or caused by consumption of unusual quantities of the food to which the individual becomes reactible. It suggests that tissues go through a process of acquiring the ability to face new proteids, or to handle unusual amounts of proteids which they have already acquired the ability to handle in smaller quantity. But since this is done successfully, it is not the sensitivity which we meet clinically, when tissues react to the extent of causing conscious discomfort, and give us the symptoms which we call asthma, or urticaria, or eczema, or any other of the allergic disturbances. These observations of what can be considered normal skin reaction when compared with allergic disease suggest that we are seeing a normal function of tissue raised to an abnormally high level. What causes this abnormal level of activity, whether it is an abnormal stimulation or a lack of normal inhibition, or some other variable, is beyond our present knowledge. Therefore, we do not understand sensitivity, and following this it is evident that we do not know the fundamental cause of clinical allergy, therefore we do not know the real cause of asthma. Until we can understand the nature of sensitivity, and how it comes to occur in the human—however much we may know of the method of production in experimental anaphylaxis—until we can know why and how certain individuals come to have tissues that are capable of reacting in this peculiar way—it is unlikely that we shall be able to apply a wholly satisfactory treatment, which, to be wholly satisfactory, must reduce this tissue reaction to the normal level, that is, to a function of which we are not conscious.. For unconsciousness of function is a state of health.

A HYPOTHESIS

Let us think a little about this function which is called into activity in allergy, in the skin, test reaction, for instance. The question of what is happening in the tissue at the site of scarification, following the application of a pollen antigen, must have suggested itself to every one of you. And it must seem evident that if this activity could be visualized we could think more clearly about allergy. I want to suggest that the phenomena presented in the wheal, the swelling and hyperemia, are the result of cell activity, a purely local activity on the part of cells that are reached by the antigen locally applied; that the cells principally involved in the skin test reaction are endothelial cells of lymphatic spaces and to lesser extent of capillaries; that the activity of the cells is *based upon their fundamental function of inclusion and digestion of proteid,* that the process is essentially an increased response on the part of this normal physiological function which results in swelling of the individual cells, some dislocation of their normal relation with each other, disturbance of their ability to act together as limiting membranes, and that consequently there occurs a transudation of serum in some way irritating to surrounding tissues, there is migration of white blood cells and often diapedesis of red blood cells.

It seems to me that this is not too fanciful a hypothesis. It is simple, of course. In fact, it is a mere skeleton. For our present purpose of trying to visualize the function underlying allergic phenomena it serves sufficiently without the further complication of discussing antibody reaction, which may be nothing more than proteid digestion specifically called into activity, or of more than suggesting that there are undoubtedly other ways in which the function is abnormal besides being simply increased. I wish only to bring out the simple thought of a heightened response on the part of a normal physiological function, a function that is the basis of cell life, that is seen in the amoeba and in phagocytosis, and that of necessity all tissue cells of the body possess; and the further thought that when this function is called into unusual activity in different tissues, each responds in its own peculiar way, muscle tissue by contraction, nervous tissue by sending out impulses, mucous tissue by an increased flow of mucus, and so on. And so the fact should be emphasized that allergy is essentially a local reaction of cells with which antigen is brought into contact, either directly or through the medium of lymphatic fluid or blood. It is so in the visible allergy of the skin test reaction. It is undoubtedly true in asthma. In other words, there seems to be no need, nor any real ground, for considering asthma a reflex nervous phenomenon. We have been at great pains in the past to assume and explain stimulation of the vagus nerve as the cause of spasm of the nonstriated muscle fibers of the bronchioles, and to

conjure up a reflex arc from the nose or the abdominal cavity for the purpose. In the light of experimental allergy, and for the sake of clear thinking, we should visualize the process as a cellular phenomenon, in which bronchial mucous membrane and non-striated muscles of the bronchi are the principal tissue involved. However, lest this be considered too strong a statement, there will be further explanation of apparent nerve influences in considering excitants of the actual allergic attack.

THE EXCITING CAUSE

There can be no doubt that foreign proteids, to which individuals are sensitive, are the exciting cause of asthma in the great majority of individuals. Clinical observation bears this out in an ever-increasing proportion of cases as experience makes us more nearly perfect in etiological diagnosis. But clinical experience is also quite convincing in presenting some apparent exceptions. Allergic-like reactions occur from physical excitants, such as dermatographia from contact irritation and urticaria from exposure to sunlight and the Alpine lamp. Heat and cold sensitiveness is coming to be considered a fairly frequent cause of asthma. Non-proteid drugs are undoubtedly a cause of asthma occasionally. And I have no doubt that there are many in this audience who will insist that they have had cases of "nervous" asthma, attacks brought on especially by emotional excitation. Many other exceptions to purely antigen action could be cited, poorly understood at the present time and imperfectly classified, but nevertheless furnishing sufficient grounds for maintaining the thesis. Two objections are made to such exceptions as the above; one that some are not true allergies, while in others it is presumed that a new form of proteid, really foreign in the sense that it is not native in the body, is produced or set free by the physical agent, drug, or nerve stimulus. It seems to me that this reasoning is based on tradition inherited from the original studies of experimental anaphylaxis, in which a proteid body produced sensitization and the same proteid, the antigen, produced anaphylactic shock. But clinical allergic sensitivity is, so to speak, naturally produced, on the basis of a cell function according to our hypothesis, so that it is no stretch of the imagination to see this cell function so highly developed in some instances that it reacts to other excitants than antigen. Probably some physical agents do bring forth foreign proteids but our therapeutic concern after all must be with the physical agent. Probably histamine is produced in the intestines under certain conditions and can cause asthma. Possibly emotional strain does in some way set free antigenic bodies but we cannot find the proteid and must deal with the individual. It is necessary, therefore, to consider this class of cases, in which the most careful search for proteid excitants gives no results and in which history must be our main reliance in attempting an etiological diagnosis. The importance of heat, cold, mechanical dust irritation, exercise, emotional disturbances, changes in barometic pressure, and so on, is not only as contributing factors, which they may also be, but as specific and in some cases the sole specific excitant of tissue activity, that is of the asthmatic attack.

This clears the way for comments on the purely proteid excitants, antigens proper. It is an enormous subject, too large to touch on more than lightly. The markedly sensitized individual, as the asthmatic must be classified, is fortunate indeed if his antigenic enemies are not widely distributed in this world of protein, or do not belong to his usual environment but are met up with only occasionally.

There are a few general principles which must be considered. Clinically, we do not deal with antigenic proteins but with antigenic substances containing the protein to which the individual is sensitized. This is frequently lost sight of in discussing antigens. Individuals may be sensitive to a number of different proteins, which would truly be multiple sensitivity, but this term should be limited in its use to stating the fact that the individual is sensitive to different substances. The question whether a given individual is in fact sensitive to one protein found in several different substances or to different proteins could be answered only after the enormous labor had been accomplished of isolating and identifying a great mass of proteins and giving them to us to be used in some form of testing that is more accurate than any of our present methods. A small start has been made in this direction but a very small one. But there is evidence that truly multiple protein sensitization is less common than we have been allowing ourselves to think, because of the fact that we have had to deal principally with gross substances without much regard for their protein makeup. In group sensitization we can presume,

in fact in some instances have proven, a single protein antigen, and group sensitization is common. But it also occurs to one, when considering the complexity of protein chemistry and the enormous labor in classifying more than a few, that proteins from widely different sources may be so identical in chemical structure as to be antigenic and yet unidentifiable. However, the point to be emphasized is that substances, not individual proteins, are what we of necessity have to hunt for at the present time. In the great majority of cases of asthma, these substances are air borne or are brought to the upper air passages by hand contact, if they are not already in contact in the form of bacteria in the upper or lower air passages. It is my experience that a much larger proportion of food asthmas than inhalation asthmas occur in infancy than obtains among adults but in infants the condition is usually atypical. It is, as it were, asthma in the making, and when it has more or less gradually developed into typical attacks it will be found that some air-borne substances are the important excitants in more cases than not. Food asthmas are more likely to be accompanied by other allergic manifestations such as pruritus, urticaria, or some form of gastro-intestinal allergy. But there are exceptions. In my experience, focal infections other than those found in accessory nasal cavities, and possibly pyorrhoea, have an even lesser numerical importance than food. Such extra respiratory infections should, of course, be considered as possibly antigenic, and also because of probable bad effect upon general health, but the position taken by some that sensitivity is caused by focal infection and will disappear with its eradication is untenable and if followed as an exclusive therapeutic principle will cause much disappointment. Clinically, however, there seems to be grounds for holding that focal infection can supplement antigenic action; in fact, I think we can go even further and maintain that heavy proteid food intake, that is, of proteins to which the individual is presumably not sensitized, can increase the frequency and severity of asthmatic attacks. It seems to be generally agreed, however, that bacterial antigens, especially in the upper respiration passage, are a frequent cause of asthma. Rhinologists realize the frequency with which sinus disease and nasal abnormalities are encountered in asthmatics and see many cases relieved or cured by their surgical procedures. But the possibility of other than bacterial antigens finding favorable conditions for absorption in abnormal nasal passages must also not be lost sight of.

Substances of animal origin are among the commonest of excitants, usually obvious to the patient when he is exposed to the animal itself, but often very puzzling when in the form of furs, wool, felt, horsehair in furniture, glue, feathers, etc. Substances of vegetable origin, in addition to the pollens which are the best understood and handled with the most satisfaction, are many and puzzling. Wood dust and smoke from wood, manufactured articles in great variety, orris, cotton, flax, turpentine, hay, straw, drugs, etc., must be considered, and, of course, food substances from almost any source. And frequent containers of antigenic substance, in most instances unidentified, are various kinds of dust, in trains, on streets, in stables, in factories, in stockyards, in houses (even in individual houses), and so on. A complete list of antigenic possibilities can scarcely be compiled and this is not my purpose in listing the above. It is only to emphasize the extent of the ground that has to be covered in etiological diagnosis.

Our present means of testing are far from satisfactory, referring especially to skin testing, whether by the scratch or intradermal methods. There are undoubtedly several reasons for this. Perhaps the most important has already been suggested, that we cannot test for individual proteins and then on getting positive results find from listed information where those proteins exist in nature. It is probable that many test substances as they are furnished to us contain such small amounts of the offending antigens that local reactions cannot be expected. At any rate, it is true that food testing is especially disappointing, however satisfactory we may have found testing for pollens and for some of the known air-borne substances. However, what knowledge we can obtain from skin testing must be made use of. Sometimes it is very valuable and seems to be the only diagnostic means. But after all, the history of the patient gives the clue, whether confirmed by testing or not. Real diagnosis must finally depend upon clinical tests.

It is not the purpose of this paper, however, to discuss the questions of diagnosis and treatment. Each is too large a subject in itself, and at least one phase of treatment is to be discussed by another essayist on the program. My main object

has been to discuss asthma as an allergic phenomenon and to suggest that progress in its management is to be attained only by thinking allergically which in our present state of knowledge must be largely hypothetical thinking.

GROUP DISCUSSION

DR. W. D. STOVALL (Madison): It has been quite a pleasure to me to listen to these papers this morning. Certainly a great deal of very interesting material has been presented to you which when properly studied and interpreted has a great clinical significance, but it is also a fact that all of these papers have been dealing with a field of medicine about which we are not certain and in which there is considerable doubt as to the method of action and its clinical application and particularly as to its usefulness in certain clinical conditions. I propose, therefore, to talk from that viewpoint for just a few moments.

In the first place, Kocher defines hypersensitiveness as a sensitiveness which is mediated through a special apparatus or mechanism which may be influenced, when properly exposed to an irritant, to increase or decrease that hypersensitiveness. If that means anything to you, you get more out of it than I do. It does not mean anything, but that does not mean to say that there is not something in the study of the reaction of the individual to protein agents and other agents which may cause reactions.

These reactions may be classified in two great divisions, that is to say those to which the individual normally reacts and those to which when a reaction is obtained there is a pathological indication, that is to say abnormal conditions. The normal reactions are the ordinary serum reactions or serum sicknesses to which a great many individuals or almost all individuals are susceptible if large enough doses are given under certain stated conditions.

The others are the susceptibilities to the various dermatitis, for instance, dermatitis venenata.

Then there is that abnormal group which may be divided into anaphylaxis, a reaction which is illustrated by the tuberculin reaction and to those conditions which Kocher classifies as atopic.

These conditions all have different manifestations and certain very different characteristics. In the first place, we speak of anaphylaxis, hypersensitiveness, allergic reactions, all within the same understanding, and as a matter of fact they mean something entirely different, except for the hypersensitiveness, and if you want to use that general term it will apply to any reaction.

The anaphylactic condition is a condition where an animal may be sensitized by an injection of a certain protein and after the passage of an incubation period if he is given another injection of that same protein he has a shock. That is an anaphylactic reaction and is specific for that protein.

The other type of reaction talked about is the tuberculin reaction. Here again we have a reaction which is specific for this condition and has no factors of inheritance. In other words, one must have been inoculated with dead tubercle bacilli or must actually have a tubercular infection in order to get a positive reaction to tuberculin.

The atopen reactions are those reactions in which a hereditary factor plays a very important part, and these conditions are illustrated by bronchial asthma and by hay fever.

Is this sensitiveness a result of the formation of an antibody by the fact that the body cell anchors a protein molecule and from that fabricates or forms a toxic agent which splits up this protein? If that is so, is it possible by the gradual inoculation of this protein to so absorb that antibody or so neutralize that antibody that the patient is not any longer susceptible to that protein? If that is so, then you have the anaphylactic phenomena, therefore allergens are anaphylactic phenomena You will not by any means find any sort of accord on that proposition. There is a wide difference of opinion on the subject. As a matter of fact, it seems quite likely that allergic conditions, these atopic conditions, bronchial asthma and hay fever, are not anaphylactic phenomena. I say it seems quite likely, it is not certain. If this were true you could make a titration process out of it so that by the use of the antibody and the antigen you could completely destroy the reaction.

We know perfectly well that this is not a simple titration proposition between a protein antigen and an antibody which is produced in the hypersensitive individual.

It is quite possible, then, that there is a difference between these reactions and ordinary anaphylactic phenomena which we know in the laboratory from sensitized animals.

What bearing does this matter have upon the use of the various tests and what is its clinical application? We must recognize, of course, that people do suffer from asthma and do suffer from hay fever, and that they are sensitive in certain cases to certain proteins, and by the proper treatment of these cases they may be desensitized so that they will be relieved for at least a period of time from their symptoms; therefore, the importance of testing out the sensitiveness of individuals to various proteins. As a diagnostic procedure they are important and are manifested particularly in skin reactions.

We recognize sensitive states; they have a certain diagnostic significance in clinical medicine. There are certain phases which can be treated and considerable relief can be given to the patients if they are properly handled. As to the relation of specific and non-specific protein therapy, it seems to me in the infectious processes an attempt at any rate at specific therapy is very much better.

DR. R. L. McINTOSH (Madison): My only object in discussing these papers is to emphasize the dermatological aspect of them. From a practical standpoint entirely, when any one meets with a case of infantile eczema or an erythema, or any kind with an urticaria or any other member of that group, one must always bear in mind the possibility of an allergic dermatitis.

I only can emphasize what has been said previously, that one should consider not only proteins as a causative agent, but any one of the non-protein causes or excitants, and having done this, one can consider also that the age or sex of the patient is immaterial.

Allergic dermatitis, as has been said, may occur at any age in any person, regardless of his occupation or anything else. The crux of the whole thing is that it takes more than the exciter, as Dr. Gray said, to produce this manifestation. The patient must have a predisposition or a tendency or idiosyncrasy or diathesis, or any one of those terms which from a practical standpoint means the same thing. It takes an allergic constitution, plus this exciter, to produce these manifestations.

I believe that if one considers allergy in connection with all these things, one can do his patient much better service.

My only other point is that the whole discussion tends to emphasize the close relationship which exists between a study of dermatology and internal medicine as we know it. It is a challenge to every skin man to become an internist and it is a challenge to every practitioner of medicine to know dermatology. There is just one dermatological phase of this question, but as has been pointed out, it is a very important one.

In skin diseases, also, non-specific foreign protein therapy is beginning to have quite a run. We have had some experience with it in granuloma fungoides and especially in large spored ringworm. In doses where a chill is obtained in ringworm, I have seen what apparently are good results after x-ray, radium, vaccines and local applications failed.

On the other hand, in granuloma fungoides, the dosage was such that no chill was present, and this patient also responded.

I have nothing further to add except that the papers

blend themselves into a very wonderful discussion of a big subject.

DR. H. S. BERNTON (Washington, D. C.): I want to take this opportunity, first of all, to thank you for the privilege of coming here and talking to you about hay fever, in which I have been interested for several years.

The last chapter in this field of work has not been written, it has been stated here, and I am entirely in accord with that view. Perhaps ten years from now you may have some one who will give you the final chapter.

The terms, allergy, hypersensitiveness, anaphylaxis, seem more or less confusing to the average practitioner of medicine. What care we about terms if we simply know the facts? Richet's definition is somewhat confusing, but after all it is very helpful to know that this peculiar property of sensitiveness is a cellular affair. What does that mean? I can best illustrate that example in the study of bakers, the men to whom we are indebted for our daily bread. I have seen several kinds of bakers. One class of men have an occupational eczema due to wheat flour; their sensitiveness is restricted entirely to the epidermis. Another class have perennial colds or perennial hay fever; their sensitiveness is restricted to the upper respiratory passages. Finally, there is a third class of individuals who have asthma, which indicates a sensitiveness from the nasopharynx down.

If you keep this example in mind, I think you will have no difficulty in appreciating the fact that all of this is a cellular affair, viz., that it is one system of cells which are peculiarly irritable or irritated by an external agent.

The treatment and the understanding of hay fever and bronchial asthma due to external conditions or due to external irritants is clear.

The causation of these diseases by conditions which come from within is not quite so clear.

Someone has said that Richet first noted and recorded the examples of anaphylaxis. We must not forget the fact that Theobald Smith in this country first really opened up the entire field of investigation, and he did so in quite an accidental way. He was at the time pathologist to the state of Massachusetts and was responsible for the manufacture of antitoxin. He used guinea pigs in the standardizing of antitoxin. In retesting animals which had survived previous injections of antitoxin mixtures, he noted that they suddenly died and presented the picture of anaphylactic shock. Any one but Theobald Smith might have overlooked the fact, but he investigated it and the subject was later taken up by the Germans who contributed additional knowledge.

DR. A. W. GRAY (Milwaukee): My paper was an attempt to emphasize the cellular theory of allergy, in contrast to the humoral. The subject of immunity in general has been greatly complicated by discussion of the probable products of cell activity, precipitins, agglutinins, opsonins, and so on, with little thought of the fundamental cell physiology which must be the source of these extracellular antibodies. I attempted also to bring out the further thought, that abnormal physiology, based on the normal cell function of inclusion and digestion of proteid, is expressed in the protean manifestations of allergy, of which bronchial asthma is one.

Periodic Health Examinations; Education of the Physician*

BY LOUIS F. JERMAIN, M.D.

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Milwaukee

The success of periodic health examination depends upon two factors. *First:* The education of the public as to the importance of periodic health examination and the benefits to be derived therefrom. *Second:* The education of the physician as to the scope and proper conduct of such an examination.

The objectives in the periodic examination of the supposedly well are three. *First:* Preventive. *Second:* Curative, by detecting disease in early stages. *Third:* To prolong life, increase economic efficiency and happiness.

This type of examination should consist of a complete inventory of the functions of the mind and body of the individual, obtained through a complete and accurate history, physical examination and necessary laboratory examinations. Periodic health examination should begin immediately after birth and should continue throughout life.

The idea of periodic health examination was probably the outgrowth of school inspection, the results and importance of which no one can deny, particularly in the decreasing incidence of acute arthritis, endocarditis, chorea and the complications of middle ear infections.

It is much easier to prevent impending disease than to cure existing disease. An experience of many years has convinced me that in established renal, cardio-vascular and other diseases, very little can be done to arrest or even alleviate, to say nothing of cure.

My choice of practice would be an examination of the well and the giving of advice as how to remain well.

The most important part of a periodic health examination is the history. A well and thoroughly conducted inquiry into the family history and personal history of the individual will lead to more information of importance regarding the future welfare and well-being of this individual than the combined information of a physical and laboratory examination will disclose. The family history is always important because it enables the physician to obtain information indicating hereditary weakness or susceptibility of the mind or other tissues and organs of the body to certain disorders and functional derangements. Thus

*Abstract of lecture before Waukesha County Medical Society, Dec. 1, 1926.

arteriosclerosis, hypertension, cerebral hemorrhage, diabetes and certain disorders of the cerebro-spinal nervous system are manifest in certain families from generation to generation as far back as information about disease is available.

The mental family history is important because the offspring of parents of poor mental balance constitute the misfits of society. They constitute the individuals who are unable to adapt themselves to their environment and marital relations, and who under the ordinary stress and strain of social and business duties and responsibilities, present psychopathic and psychoneurologic disorders.

The past history of the patient's life is of equal importance because it gives the physician information concerning events of his past life which may have resulted in damage to either his mental or physical structure. Diseases he has had—his psychic reactions to pain, sorrow, work or misfortune. Sleep, how much he gets and how much he needs. One individual needs eight hours' sleep in order to be able to function properly, while another gets along very conveniently on six hours. Food, how much he eats; how much he needs. One person can maintain his weight and strength on a small quantity of food, while another needs double this amount for proper nutrition and activity. It is questionable whether or not the established custom of eating three meals a day is a good one. Would it not be better for many of us if we ate only when we are really hungry?

Every experienced physician knows that a large percentage of the suffering and distress of the human race is not physical, not even functional, but is mental, hence the importance of a careful survey of his hereditary and acquired mental characteristics and peculiarities. Proper advice and guidance in this respect will prevent much mental disease and incapacity. It is the only certain way in which it is possible to reduce the population of our eleemosynary institutions.

In the physical examination of such a periodic health examination, thoroughness and method are again necessary in order that the individual may benefit therefrom and receive full value for time and money expended.

Careful inspection is the most reliable method of disclosing the actual physical condition of the individual. General inspection gives valuable information about the nutrition, color, expression, posture, gait and emotions, etc. Then each region of the body should be carefully scrutinized. Head, eyes, ears, mouth, teeth, throat, neck, chest and so on until the entire body has been covered. Careful observation and inspection was the means by which the practitioner of pre-laboratory days made his diagnosis. It is no less important at present although often sadly neglected.

Palpation of the body should next be carefully carried out. Most cardiac disorders and many pulmonary disorders can be accurately diagnosed by careful inspection and palpation alone. Practically all abdominal conditions must be diagnosed from the history and by means of careful inspection and palpation. A cardiac murmur, for instance, is of little or no significance unless inspection and palpation reveals evidence of disease.

It has been stated that periodic health examination would fail because of the cost of laboratory work. In a periodic health examination we are dealing with presumably healthy individuals, the only laboratory examination necessary as a routine is a urinalysis and perhaps occasionally a blood count. This can be carried out without much additional cost.

Furthermore, a periodic health examination is an examination that can be carried out by the rural practitioner as well and just as efficiently as by the city practitioner with well-equipped laboratories. All that is necessary is proper training in method. An intelligent use of our special senses, and the mind and intelligence to interpret what these senses reveal.

An efficient and satisfactory health examination is more difficult than an examination of the sick. The sick individual comes with a definite complaint which can be investigated and analyzed. The health client has no complaint and any deviation from the normal must be elicted by a thorough and well-conducted history and physical examination.

DIPHTHERIA IMMUNIZATION IN PROVIDENCE

On the basis of more than three years' experience in Providence, involving the Schick testing and immunization of some 15,000 children, it would appear that toxin-antitoxin immunization eliminates approximately 90 per cent of the risk of contracting diphtheria in the immunized groups. During this time 38 per cent of all children in the age group 5-9 and 24 per cent of the children in the 10-14 year group have been immunized. In the group under 5 years, in which the morbidity and mortality from diphtheria are practically at their height, hardly 4 per cent of the children have been immunized. To make immunization wholly effective, some method must be devised to reach this susceptible group. To meet this need the health department is sending to the parents of every 6-months old child in the city a notice urging immunization by the family physician or at a clinic. According to Clarence L. Scamman and Alton S. Pope, New York (Journal A. M. A., Feb. 19, 1927), results of the campaign can already be seen in increased demands on physicians and preschool clinics for immunization against diphtheria.

THE JOURNAL CLINIC

Diagnostic Problems

BY L. M. WARFIELD, M.D.
Milwaukee

In the April JOURNAL we presented the case of a woman 51 years of age who had been passing through a long menopause for the last six years. She had gradually gained 30 pounds in weight during this time and had a blood pressure of 150/84 and negative urine. She complained of some shortness of breath and skipping of heart beats.

DISCUSSION

There is nothing difficult about the diagnosis of this case, but there are certain features about it which make it both interesting and important.

The profession has not yet learned that simple high blood pressure without any kidney disturbance occurring in women following the menopause is a very common condition and cannot be looked upon as a very serious matter. The hypertension of the menopause has been known for some years. Many men have called our attention to it and all have agreed that it probably represents some profound endocrine disturbance associated with the cessation of the menstrual function. This woman, as so often occurs in many women of this age, not only has passed through the period when the ovaries have ceased to function but at the same time she shows evidence of hypo-function of the thyroid gland. The intimate association of the ovarian internal secretion and that of the thyroid has long been recognized.

The gradual gain in weight at this period shows that the body has slowed down in its metabolism and although it is not always possible to show a lowered basal metabolic rate, nevertheless one cannot but doubt that the thyroid has ceased to function as it formerly did.

Hypertension in such people is probably the result of a combination of factors producing spasm of the blood vessels, a condition now called vascular or essential hypertension. The heart of this woman measured with the orthodiagram a transverse diameter of only 11.1, which is quite a normal sized heart, and there was no evidence at this time of hypertrophy of the left ventricle. The extrasystoles which this woman had is not an unknown finding, and unless combined with some other evident myocardial disease, cannot be looked upon as an evidence of heart weakness.

The shortness of breath which she complained of was not that of myocardial disease. It was no more than the usual breathlessness noted by stout people who are not exercising much.

In the treatment of these people the important point is to assure them that they may outlive any member of the family. The administration of ovarian extract with a small dose of thyroid extract (gr. ¼-½ t.i.d.) certainly seems to help. Attention to the bowels and sound advice in regard to eating habits are also points of importance in the treatment. Removal of *evident* foci of infection is justifiable but sane judgment should be exercised in recommending removal of suspicious teeth and tonsils.

The prognosis is usually good although a small number, after years, may develop some kidney disturbance with lowered function.

A NEW PROBLEM

Mrs. P. C. O., whose age was 54, and whose occupation was a housewife, was taken to hospital with the history that about three weeks before she had a full feeling in the abdomen. She was frequently dizzy, her bowels were loose, but there was no blood in the stools. Up to that time she had been quite well. She had always been able to do all of her housework and considered herself a very healthy woman. She had not lost weight. Her appetite and digestion had always been good. Her bowels were regular. She had passed the climacteric without any distressing symptoms and there was no history of pelvic trouble. There was nothing of importance in her family history, her parents both having been long-lived. When she entered the hospital, her height was five feet, two inches, and her weight 146 pounds. She was a very well nourished woman. There was slight fever of 99.2; the pulse was 82; respirations were 22. The heart and lungs showed nothing abnormal. The abdomen was distended, symmetrical. There was no tenderness on palpa-

tion, and no definite masses were felt, although there was a resistance to palpation in the upper abdomen. There was also some shifting dullness in the flanks. The reflexes were all present and normal. On account of the distended abdomen a vaginal examination was unsatisfactory. Only the cervix could be felt which was smooth and virginal.

After she had been in the hospital about 10 days she was seen by me in consultation. During that time, several examinations of urine had been made, all of which showed fairly high specific gravity, a trace of albumin, but no sugar and no casts. The hemoglobin was between 50% and 60% (Talquist); red cells between 3½ and 4½ million; white cells were between 5,000 and 7,000. Study of the temperature chart showed there had been slight irregular fever, never more than 99½° F. On physical examination the only change found from previous examinations was in the greater distention of the abdomen which made it impossible to palpate even a resistance in the epigastrium. Her nutrition was good, flesh firm. There was no edema of the legs. The distention of the abdomen was great, the skin tense. The abdominal fluid was bloody—serous—no special examination was made of it.

Subacute Bacterial Endocarditis: A Case Report*

BY R. H. STIEHM, M.D.
Madison

A Scotch housewife, sixty-seven years old, was admitted to the Wisconsin General Hospital August 24, 1926, with the complaint of goiter.

Since the first of January, 1926, the patient had not felt well. Her heart beat very rapidly, there was occasional swelling of the ankles and she became short of breath on exertion. She also became dizzy when assuming the erect postion and was troubled with tinnitus. Six weeks before her admission, about July 1st, patient lost her appetite, suffered a great deal with generalized headaches, most marked in frontal region, and remained in bed because of extreme weakness. At intervals during the six weeks before admission and daily during the last two weeks, the patient had. as she describes, the following sensation: Awakening in the morning with a prickly sensation in her hands, she would break out in a profuse sweat, extreme enough to soak her night gown. The sweat was generalized and was not preceded nor followed by a chill. After these attacks the patient felt achy, weak and tired.

The patient's history was negative except for measles and whooping cough in childhood, and probable diphtheria in early adult life. The winter before admission the patient had frequent attacks of tonsillitis.

Physical examination showed an anemic, rather poorly nourished women lying flat in bed with marked pallor of skin, flushed cheeks and sub-cyanosis of mucous membranes and nail beds. There was slight edema of the lower lids. The right pupil was larger than the left. The vessels of the fundi were tortuous and sclerotic. The mucous membrane of the nose appeared inflamed. The tonsils were not visible. The gums were soft and bled easily. The remaining teeth were loose and carious. The thyroid gland was enlarged, most extensively in the midline and was apparently cystic. The lung limits were normal and no pathologic signs were elicited. The heart was definitely enlarged, the left border extending 133 mms. from the midsternal line in the fifth interspace A strong heaving pulsation was visible and easily perceptible by palpation. Auscultation revealed a loud systolic murmur, crescendo in character, and ending in a whiff over the pulmonic area. The aortic second sound was not audible. A coarse, harsh systolic mitral murmur was present at the apex and was transmitted to the axilla. The superficial arteries showed marked thickening and sclerosis. The pulse was of good quality. The blood pressure was 100/54. Electrocardiogram showed normal rhythm with left ventricular preponderance. X-ray for heart size brought the following report:

	Area	Trans. Diam.
Normal for height and weight..	107 sq. cms.	12.2 cms.
Present measurements	119.4 sq. cms.	13.3 cms.

The liver extended slightly below the costal border and was palpable. The spleen and both kidneys were palpable. The inguinal glands were somewhat enlarged.

From the history and findings the following diagnosis was made:

Subacute bacterial endocarditis
Cardiac hypertrophy with mitral insufficiency
Myocarditis
Arteriosclerosis
Secondary anemia

A blood culture was done the day following admission which was found positive for streptococcus viridans. During the patient's stay in the hospital, eleven cultures were made, all except three being positive for the above organism.

Daily urinalyses over a period of a month showed acid reaction and traces of albumen on most occasions, and always showed many white blood cells. No red blood cells were ever discerned. A blood Wassermann was negative. Blood examination at time of admission showed 70% hemoglobin, 4,770,000 red cells, 7,600 white cells with 86% neutrophiles. 11% small lymphocytes and 3% large lymphocytes. The blood picture six weeks later showed 36% hemoglobin, 3,210,000 red cells,

*From the Department of Medicine, State of Wisconsin General Hospital.

7,450 white cells with 87% neutrophiles, 1% eosinophile and 12% small lymphocytes. The blood examinations in the intervening time, of which there were six, showed a gradual progressing anemia; the interesting thing in the differential count being the high percentage of neutrophiles which on all occasions except one were above 84%, one count showing 76%. The blood sugar was 100 mg. per 100 c.c. The non-protein nitrogen was 37.4 mg. and the uric acid 4.4 mg. per 100 c.c. blood.

The temperature showed a daily rise, usually about 98.6 degrees at the lowest level and reaching as high as 103.4 degrees in the afternoon, the average daily rise being to about 102 degrees. Respiration varied from 20 to 36, going up to 40 just prior to patient's death.

August 30th, six days after admission to hospital, many petechiae, appearing in showers, were noted at the lower left costal border. Apical impulse on this date suggested pulsus alternans, but this was not borne out by blood pressure determination. September 7th, a new crop of petechiae was noted at the costal angle and temperature had again assumed a higher level. Throughout the patient's stay in the hospital, new crops of petechiae were noted about every third day. October 4th, numerous small ecchymoses and petechiae were noted over the chest, arms and abdomen.

Later in the same day, the patient was found lying on her right side, with right arm hanging over edge of bed, left arm and leg were rigid, eyes were half closed, respiration slow and shallow, pulse weak. Face was pale, pupils reacted to light and accommodation, were of equal size and neither dilated or contracted. The right arm was more flaccid than left, reflexes equal on both sides. There was a definite right sided facial paralysis. Patient could not be aroused from her comatose condition.

Patient's general condition became worse. Pulse gradually became more rapid and irregular. Respirations became more rapid. There was evidence of pulmonary congestion. Petechiae over abdomen, chest and legs became more extensive. October 6th, 45 hours after stroke, patient died without having regained consciousness.

Review of the Case

Notes on the history:

The age of the patient first attracts our attention. A report of 317 cases observed by Blumer[1] showed only four cases occurring in the seventh decade. The occurrence is most common between the age of 10 and 40 (256 cases 81%), the largest number occurring in the third decade.

The complaint of "goiter" probably was based on the diagnosis by former clinicians. The history does not entirely contradict this statement; the rapid heart rate, the extreme weakness, shortness of breath on exertion, extended onset, and tinnitus all lend force to this conclusion. However, when we consider the loss of appetite, the prickly sensation in her hands followed by drenching sweats which left the patient weak and tired, we must think of infection. The past history means nothing in the present relation except the frequent attacks of tonsillitis which must at least be considered as a probable source of the present heart condition.

Notes on physical examination:

General observation of patient, the oedema of the lower lids, subcyanosis of lips and nail beds, the pallor and the contrasting flushed cheeks indicate cardiac involvement. The carious teeth may be another source of infection for the existing condition. The enlarged, cystic thyroid suggests that it may be the cause of patient's symptoms. The cardiac hypertrophy, the murmurs, rapid rate, and heaving pulsation mean evident cardiac pathology, either active or passive. The thickening and sclerosis of the vessels are to be expected at the age of sixty-seven.

Eight of the eleven blood cultures showing streptococcus viridins make more evident that in these cases positive blood cultures are usually encountered. The above organism is the most common met with. In 304 cases studied by Blumer, the streptococcus was isolated from the blood in 248; the viridens type being noted 169 times.

The blood counts are as one would expect, the anemia being progressive, secondary in type, and usually of a moderate grade. The white blood count was at no time over 10,000, and Blumer's records show that in contrast with other pyococcal infections, a considerable proportion of patients show no leucocytosis. The high percentage of neutrophiles with a correspondingly low total count should suggest a grave prognosis. The blood chemistry is normal as is usually the case.

The febrile reaction is not usually high, though the temperature is somewhat dependent on the infecting organism, Schottmüller[2] stating that cases due to streptococcus hemolyticus usually give severe febrile reactions. The temperature depends, too, on the reaction of the individual to the infection. At no time was the temperature recorded directly after or during the period of the patient's sweats which occurred each morning. It is very probable that at that time the temperature was the highest during the twenty-four hour period. The cause of the early morning sweats is a problem. Would it be far-fetched to assume that during the lull in the resistance of the body during the early morning hours when the basal

metabolic rate is at its lowest level, the infection got the upper hand, and that the body in a later response brought about a reaction manifested by a chill with marked elevation of temperature?

Treatment consisted of the ordinary hygienic and dietetic care necessary in a febrile rise. No successful specific treatment of subacute bacterial endocarditis has yet been found. The presence of the frequent crops of petechiae is due to minute emboli circulating in the blood stream. It is probable that the prickling sensation noted in the fingers each morning was also due to emboli lodging in the end arteries. Petechiae often portend, as in this case, some grave embolic disaster; a focal lesion in the central nervous system being the cause of death.

The autopsy report gives the following anatomical diagnosis:

"Arteriosclerosis; chronic mitral and tricuspid endocarditis; cardiac hypertrophy; chronic fibrous myocarditis; subacute vegetative mitral endocarditis; acute splenic tumor; cloudy swelling of viscera; subpericardial hemorrhages; hemorrhages in the bladder and intestine; infarcts of spleen and kidney; tuberculous apices; cholelithiasis; multiple myomata of uterus; slight hydronephrosis, left side."

The description of the heart follows:

"The heart is slightly enlarged and weighs 315 gms. On the surface of the left ventricle and on the floor of the aortic arch there are definite opaque whitish patches. Scattered over the surface of the right auricle and right and left ventricles there are a few minute subserous hemorrhages. The right auricle and ventricle are dilated. The tricuspid valve shows a definite thickening along the line of closure and at the free edge. The orifice measures 11 cm. The pulmonary valve segments are delicate and normal. The orifice measures 6 cm. The left auricle is dilated and its wall slightly hypertrophied. The foramen ovale is anatomically open. The left ventricle is somewhat dilated and its wall thickened, varying from 13 to 15 mm. in thickness. The muscle is cloudy in appearance and shows here and there small grayish areas of fibrosis. The mitral valve is definitely thickened and it shows numerous elevated opaque vegetations. A few of these are along the line of closure of the posterior leaflet and one even lies on the auricular lining above the attachment of the aortic leaflet. The aortic orifice measures 8 cms. The coronary arteries are open and show no sclerosis. There is moderate sclerosis of the base of the aorta which is dilated above the valves until at a distance of 3 cms. above them it measures 9 cms. in circumference."

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Congenital Atresia of the Esophagus

BY JAMES E. McLOONE, M.D.
La Crosse

Not knowing the cause and being unable to remedy the condition, this most common of esophageal anomalies is reported for the interest it may stimulate in a possible correction of this fatal birth deformity.

Mrs. D. entered the hospital Feb. 25, 1927, in labor and delivered a 6½-pound girl in seven hours. This was the fourteenth pregnancy and the ninth child. Previous labors have always been normal. Patient on entrance had a marked hydramnios and a marginal placenta praevia. At the end of seven hours in the hospital the bag was ruptured and a spontaneous delivery ensued. The child appeared normal in all respects at the time of delivery and was of good color which improved upon crying. About one-half hour after birth, child suddenly turned very blue. Aspiration of esophagus and pharynx obtained considerable mucus. Child rallied and remained so until it was fed water by the nurse when the same condition resulted. Baby would take one or two swallows of fluid and in a few seconds become very cyanotic, gasp and regurgitate fluid through nostrils. The abdomen of the child was not distended in its upper portion as in cases of Brennemann.[1] However, the diagnosis of congenital atresia of the esophagus was made, and all feedings by mouth stopped. Fluoroscopic examination was made, feeding child barium milk, giving the findings seen in Fig. 1. The opaque material entered the esophagus for a distance of 3 to 4 cm., dilating it, and was then regurgitated through the mouth and nostrils. No opaque material was seen to enter the trachea nor was an air bubble present in the stomach. Our conclusion was an uncommunicating congenital obstruction of the esophagus on fluoroscopic examination. The child died of starvation and bronchopneumonia on the seventh day.

At autopsy the peritracheal and esophageal tissues were carefully dissected to determine a possible communication between the trachea and esophagus as in the cases reported by Brennemann,[2] Cautley,[3] Kastner,[4] and others. None such was

found, although from the report of Plass[5], this is most frequently the case; that is, the lower portion of the esophagus and trachea are communicating.

Both the upper division and the lower division ended in blind sacs united by a thin white cord-like tissue. The upper portion of sac extended to just below the substernal notch and the lower for about 5 cm. from the cardiac end of the stomach. Other than the bronchial pneumonia, the remaining viscera appeared normal as in the case reported by Crowdy.[6] Mother's and baby's blood (Wassermann) were negative.

The etiology of atresia is necessarily speculative. Shattock[7] offers the theory that when the pouch, from which the lower air passages develop, is

Fig. I.

formed from the anterior wall of the mesenteron, the posterior wall occasionally participates in the process sufficiently to be drawn forward, thus narrowing the lumen. When subsequently the lateral pouching for the formation of the larynx develops from the stomodeum just above this region, so much of the already narrowed lumen is consumed that the connection between the upper and lower portions is left communicating with the air passages.

Giffhorn[8] believes that the lateral folds, from which the air passages develop, unite at one point with the posterior wall of the esophagus, causing atresia; while below they are unable to unite in the normal manner in the midline and thus permit a fistulous communication to remain. Supposedly in like manner may be explained those cases in which no communication exists between the esophagus and trachea.

The symptomatology of this condition is definite and clear cut. Following taking of food in but small amounts the somewhat cyanotic child becomes suddenly more so and regurgitates food and mucus through nose and mouth. The cyanosis is dependent upon the amount of food that enters the trachea directly or by aspiration. The diagnosis is readily confirmed by feeding the child barium milk and watching the passage of opaque material under the fluoroscope. The failure of passage of the liquid into the stomach with dilatation and obstruction occurring at or above the bifurcation of the trachea establishes the condition as probably congenital.

The prognosis to date has always been fatal for these babies; the extent of life being from one to two weeks. Operation procedures have been attempted by Richter[9] and Weiss[10] without success. Death usually followed in twenty-four to forty-eight hours, although Weiss did have one case live longer. He operated a six-day-old infant, doing a gastrostomy, which lived twelve days, dying of bronchopneumonia. Richter attempted unsuccessfully to close the tracheo-esophageal fistula in one case and do a gastrostomy. Jejunostomy has also been tried but the infants are unable to withstand the operative shock in all procedures.

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Gastralgia in Tabetics Addicted to Morphine*

BY BENJ. H. SCHLOMOVITZ, M.D.
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Very often the difficulty in alleviating the various pains of the syphilitic tabetic, both during and after the most exacting treatment, finally forces the practitioner to use morphia therapy. A problem presents itself, then, after what is considered an adequate amount of treatment has been given sufficient to produce some clinical improvement. This problem is to differentiate the subjective symptoms of recurrent epigastric distress which the patient still claims is that of gastric crises in their original or modified form, from the epigastric distress, real or apparent, of chronic morphinism. As Stokes and Shaffer[1] have recently emphasized, "the combination of morphinism and gastric crises is as distressing and refractory as anything in medicine." The intelligent patient fitfully resents the imputation—addict—and attributes the use of, what he calls, the "medicine" (not *drug* because this term has for him a patho-psychological slant), to relieve his nausea, vomiting, and epigastric pain.

The continued use of the narcotic by a patient late in the course of rigid treatment is a two-fold evil. It clouds the judgment of the physician as to the progress of the cure for the lues, and also continues to make the patient an economic burden and unsocial creature. Many treated and untreated cases of tabes have been reported in which there has been an arrest of earlier improvement of all symptoms except the epigastric distress. While opiates are being taken there is no way of knowing whether this symptom of epigastric distress which was the original excuse for taking the narcotic has disappeared. In addition, the doctor knows that the issue is confused because gastric distress can occur as a withdrawal symptom in chronic morphinism. The following case illustrates these points:

A married woman, age 29, was first seen in August, 1923, for an attack of gastralgia. She had all the salient features of a tabes dorsalis. The first course of antiluetic treatment had been instituted three years previously. For two years she had been given mercury intramuscularly, salvarsan and neosalvarsan intravenously and five intraspinal injections. There had been no treatment for more than a year after that. For a number of years previous to the first course (1921) of anti-syphilitic treatment, she had had epigastric distress which resulted in five abdominal operations with no relief, and also during that same interval she had had three miscarriages. Upon further examination of her medical history, the first possibility of an initial luetic lesion could be placed eleven years before she was first observed by us. Her weight was 98 pounds. She insisted upon being given morphine for her pains. Shortly after our first observation she was given large doses of sodium iodide intravenously and at the same time a sedative mixture of sodium veronal, sodium bromide and pyramidon, and at other times pantopon tablets. In September, 1923, tryparsamide and mercurosal treatment was instituted. This was followed up by a period of mercury cyanide and neosalvarsan intravenously.

There was a gradual improvement in her condition but apparently no alleviation of the gastric distress nor any marked reduction in the use of narcotics. Therefore, a thorough roentgenological examination of the gastro-intestinal tract was made, including drainage of the gall bladder, to see whether after all there was pathology present necessitating surgical interference. The examination was negative.

She had given up the use of a catheter after the tryparsamide treatments and there was nothing to indicate that the pain complained of was of genito-urinary origin. The patient was presented with these negative findings and told quite bluntly that she was an addict. If she desired to maintain her self-respect and that of her family that she must consent to a morphine cure. Only then could we be sure that her syphilitic gastralgia had been alleviated or arrested.

She agreed to take the cure July, 1924, after being warned of a possible cardiac irregularity and palpitation which we believed were evidences of a low grade myocarditis amply demonstrated by Warthin of Michigan as a frequent sequel in lues. Under scopolamine hydrobromide, veronal and aspirin, she was maintained in a subconscious

*Permission to publish granted by Col. B. F. Haydon, N.H.D.V.S., Dayton, Ohio. Read before Milwaukee Academy of Medicine, 1927.

stage for more than a week. Digitalis was given when marked irregularity of the heart developed. For a month longer she was kept under the care of a nurse. For a short period she was given fifteen grains each of sulphonal and trional in the evening. Cream-buttermilk and oil relieved a long-standing constipation which induced occasional distress. She was then sent up to a farm and forbidden the use of any medicine at all.

Within six months her weight had gone beyond 130 pounds, and there was no further evidence of epigastric distress. Her physical condition remains good now after two and one-half years. She dismissed her housekeeper and resumed control of her household. At present she is dividing her time at home and in a business project.

This case demonstrates how the complaint of epigastric distress in tabetic *morphin* addicts can mask their progress, and permits us to recall again the words of Stokes that the cardinal error of the profession in dealing with gastric crises at the present day is in the use of morphin.

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C. D. LEAKE, EDITOR

HYPERTROPHY AND DILATATION OF THE HEART

BY J. A. E. EYSTER, M.D.
Madison

Comparison of the distribution of measurements made from frontal orthodiagrams with the predicted normal curve (Hodges and Eyster—Am. Jour. Roent. & Rad. Thera., 1924, xii, 252) and (Arch. of Int. Med., 1926, xxxvii, 707) shows that the presence of cardiac hypertrophy can be determined in man with a degree of precision comparable with that of other methods of proven value in clinical diagnosis. In the experimental animal an acute lesion producing cardiac overload (injury to aortic valve, aortic band, septal puncture) results in a transitory period of dilatation from which the heart recovers within the course of three to ten days. This is in turn succeeded by hypertrophy of the muscle. During the period of dilatation there are microscopical changes present in the muscle indicating injury. These also disappear as hypertrophy develops. The dilatation and recovery are not associated with significant pressure changes in the right auricle, i. e., they are not due to general dynamic changes in the cardiovascular system. The possible relation of the period of dilatation, with associated muscle injury, to the subsequent hypertrophy is of great interest, and it has been found that hypertrophy may develop when the overload producing the dilatation is removed before hypertrophy develops. The prevalent theory of cardiac hypertrophy, that of work hypertrophy, must be modified at least to include another factor, that of cardiac injury due to stretching of the fibers in dilatation.

This factor appears to be alone capable of producing hypertrophy, and may, in every instance, be a necessary precedent to the development of hypertrophy. Clinical x-ray evidence is presented to show that simple cardiac stimulation (hyperthyroidism) or a gradually developing overload without dilatation of the heart (essential hypertension) does not lead to hypertrophy.

DISCUSSION

In discussing Dr. Eyster's paper, Professor C. H. Bunting said that the histological picture in these hearts showed that the musculature at the apex stretches upon putting the extra load on the heart. It has been noted by Macallum that the muscular fibers of the heart are weaker at the apex. It is this factor which is responsible for the lengthening of the heart when overloading takes place. Pathological hypertrophy is preceded by injury. Dr. Eyster has added more evidence to support the proposition that all pathological hypertrophy and hyperplasia is preceded by injury. Histologically, the specific injury in these hearts consists of hydropic degeneration, especially in the Purkinje cells, but also in the muscular tissue, which is then followed by hypertrophy.

December 7, 1926.

ADMINISTRATION OF COD LIVER OIL

Henry J. Gerstenberger, Cleveland (Journal A. M. A., Jan. 22, 1927), advises that cod liver oil should be given once daily on an empty stomach and when most of the family members are likely to be at home. In other words, the cod liver oil should be given in whatever dose thought necessary before breakfast. If under these circumstances the child vomits its first dose, a second should be immediately administered. As it also is a good policy to see that an antiscorbutic substance is administered daily, a small amount of orange juice, if desirable, may be taken immediately after the cod liver oil has been swallowed. The parent, however, is advised not to offer the orange juice as a reward or as a "chaser," but to get the child to understand in the first place that cod liver oil is essential to his welfare, and in the second place that he will get accustomed to its taste within a week or ten days

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FOR THE COUNTY SOCIETY

1. *Program Material.* Pursuant to authorization by the 1924 House of Delegates the Secretary is arranging to make program material available without cost. The following can now be secured:

A. Departmental Officers of the State Board of Health. Address Dr. C. A. Harper, State Health Officer, State Capitol, Madison, Wis.

B. Clinicians of the Wisconsin Anti-Tuberculosis Association when in vicinity. Address Clinic Dept., W. A. T. A., 558 Jefferson Street, Milwaukee.

C. Councilors and Officers of the State Society. Address the individual.

2. *Annual Statements.* Uniform annual statements can be had without cost. Address the Secretary, advising number desired.

EDITORIALS

THIS MATTER OF HEALTH

DR. GEORGE E. VINCENT, President of the Rockefeller Foundation, put it bluntly, but loaded it with truth when he characterized health as "a boresome thing." People, he said, like to talk about their ills (something which every doctor knows). It becomes a fascinating theme—this matter of diseases and all their ramifications, and just naturally gravitates to the fore at the afternoon tea. "A sanatorium is a clearing-house for symptoms," said Dr. Vincent.

Public and personal health is important, all are agreed. But few get excited about it. It is the abnormal in the news of the day that draws the biggest spread in the daily press. The fact that a dozen children die in a crossing accident makes sensational news, warranting heralding over the entire country. Diphtheria can take the same number of lives, one by one, in any city, with no more than passing attention. So, too, whooping cough may take a daily toll with hardly more than the usual obituary mention. No flaring headlines for these. Yet, were scientific procedures for diphtheria utilized, and official restrictions for whooping cough followed to the letter, these lives might be saved just as surely as ordinary precautions would have saved the children at the railroad crossing. The cases of the sick children are taken for granted; the automobile accident seems the more tragic, yet is not a whit more so.

The peculiar psychology existing in the attitude of many in elaborating to friends and in social gatherings their "aches and pains," tired feeling, and sleepless nights, when all too frequently these symptoms may be the result of ignorance or indifference to a few fundamental facts pertaining to their personal health, is known to every physician. Such individuals would resent it if their failures in business and the social world were charged to a lack of knowledge of the fundamental principles underlying such activities. Generally speaking, individuals tend to elaborate on their successes in the business and social world while in the matter of the health of the body it is the failures and not the successes that receive elaboration. By applying the same attitude to health as is given to social and business activities, there would be less tired ears and fewer sanatoria.

When the individual is enjoying normal health it is his tendency to forget about it. It is dull business—this keeping well. So he goes on his accustomed way, indifferent to the danger of acquiring the seeds of constitutional diseases or infirmities that a periodic examination would bring to light in time for early correction.

But there is a shifting of the emphasis coming now. Periodic medical examinations are bringing many a person to see health in a new light—the preventive plan. It is a shifting of emphasis for the doctor, too, for as he must be trained to diagnose and treat disease, so must he be trained to look for health by the shortest route. We are told that medical schools will have to lay more emphasis upon this particular training for their graduates. It is in line with the aims of the American Medical Association in stressing periodic health examinations. Life insurance companies made it pay in terms of millions saved.

Whether in disease and its cure, or in health and its preservation, the sincere medical man and conscientious health worker will give his best efforts, striving always to point the way to health by rational ways of living, teaching that by avoidance and prevention the goal will more surely be found.—*C. A. H.*

LIVE STATISTICS

PREVIOUS reference has been made in these columns to the Metropolitan Statistical Bulletin, the writer finding this one of the most fascinating publications that come to his reading table. As has been said before, the Metropolitan figures, unlike those of the United States Federal Bureau, are not ancient history by the time they reach the reader. And for such practical uses as a physician or health officer may have of vital statistics reports, they serve admirably to give one the trends of "fashions in death and disease."

Here follow a few of the outstanding and significant items copied from the report:

"For the second time in the history of the American and Canadian industrial populations, the death rate for tuberculosis was below 100 per 100,000; yet 1926 with a rate of 99.2 shows a slight increase over 1925 which had a rate of 98.2." "1925 was possibly the low point which probably will be difficult to better for some years." "When the 1926 report of mortality from tuberculosis, by color and sex, becomes available, we believe that the increase recorded for the policy holders is due

to a rise in the colored deathrate." "The first nine months of the year showed a slight decline among the white policy holders which was a little more than counterbalanced by an increase among the colored policy holders."

"The 1926 mortality from heart disease increased 57 per cent in 1926, as compared with 1925."

"There were smaller increases for chronic nephritis and cerebral hemorrhage. These rises are in part reflexes of the influenza outbreak of the early part of last year."

"Requests have come to the Metropolitan to analyze and publish its alcoholism death rates for the entire period 1911-1926.

"In order to make a fair comparison for prohibition and 'pre-war' years, it will be necessary to eliminate the more than 1,000,000 Canadian policy holders, among whom there are relatively few deaths from alcoholism. It will be necessary to add deaths reported from wood and denatured alcohol poisoning, which have been fairly frequent since 1920. The study will be made and the results published in a forthcoming number of the Bulletin. During the five years, 1922-1926, there occurred 2,295 deaths from alcoholism among Metropolitan Industrial policy holders. Of these, 2,270 occurred among approximately sixteen million persons in the United States, and only 25 among approximately 1,000,000 Canadians. Deaths reported from acute poisoning by wood or denatured alcohol numbered 29, as compared with 24 in 1925; 20 in 1924; 27 in 1923; 36 in 1922; 71 in 1921; and 90 in 1920."—H. E. D.

A MORAL OBLIGATION

THE National Tuberculosis Association has published a booklet showing the extent of supervision by state governments of anti-tuberculosis work. From the standpoint of the public health agencies, one tabulation which they publish is of considerable interest as showing the extent to which tuberculosis is reported in 42 states, the District of Columbia and the Philippines. Of these 44 units, eight states and the Philippine Islands are not in the U. S. registration area.

It is interesting to note that in the 26 registration units which report more cases of tuberculosis than they record deaths from this disease all are in the registration area for deaths except New Mexico and the Philippines, while of the eighteen states which report less than one case of tuberculosis per annual death, eleven are in the registration area and seven are not.

The state in which reporting of tuberculosis is best done is Kansas with 330 cases per one hundred deaths, while in Iowa the reporting is less then ten cases per one hundred deaths. Wisconsin just misses falling into the group which annually reports fewer cases than deaths, the proportion for this state being 110 cases per one hundred deaths.

How far short of the actual number of tuberculosis cases existing is the number reported can be seen by comparing the proportions of cases to deaths here cited with the Framingham survey which disclosed the fact that for each one hundred Kansas, which leads in the completeness of its deaths from tuberculosis there existed 900 cases. tuberculosis reporting still falls two-thirds short of the possibilities, while Wisconsin has official knowledge of only one case out of nine. This is by no means an enviable record.

The sources of these case reports are not mentioned in the survey. It is fair to assume, however, that while perhaps most of the cases reported are placed on record by practicing physicians, a not inconsiderable number is recorded by official and voluntary health workers through discovery clinics.

The Public Health Reports issued weekly by the United States Public Health Service carry a standing motto at the head of the section devoted to prevalence of disease—

"No health department, state or local, can effectively prevent or control disease without knowledge of when, where and under what conditions cases are occurring."

Any physician considering the data here presented may well stop to consider whether he has given the public health authorities in whose jurisdiction he practices, knowledge of when and where tuberculosis cases under his care have occurred. Such reporting is not only a legal duty, but a moral obligation. More than that, it is a golden opportunity to make available to the families of tuberculous individuals, the information necessary to protect them from infection. Tuberculosis is a family problem: it is a social problem at least as much as a medical problem if not more so. It requires not only medical treatment of the patient by the family physician or the sanatorium, but social and economic consideration by the forces specifically organized to grapple with these phases of the situation.—*W. W. B.*

PROTEIN DIET AND NEPHRITIS

THERE seems to be a very widespread feeling among physicians that diets containing protein are harmful to patients with both high blood pressure and nephritis. Again and again the writer has seen patients who have been told that as they have one or the other or both of these conditions they should live on a diet containing no eggs or meat. This diet is not harmful and the prohibition of all animal protein is unnecessary.

I have not been able to trace this idea under criticism to its source but there are certain experimental reports which apparently confirmed it. Newburgh and Marsh, for example, published the results of high protein feeding in rabbits. They said that they found nephritis with cellular elements and casts in the urine. When one became acquainted with the methods they employed in their work it was evident that their results were open to criticism, and not long after several workers, both in this country and in England, failed absolutely to confirm their results.

There was apparently a preconceived idea that proteins were harmful and the negative results fell upon prejudiced minds. This is all the more remarkable because of the fact that there is one huge natural experiment which has been going on for generations among the Esquimaux. Their diet is meat and fat. That is all. There is no record of an increased incidence of nephritis among them. Then the explorer, Stefansson, lived for a year upon the meat and fat diet, and in spite of hardships during this time he was found some months later to be free from all evidences of hypertension or of nephritis.

Recently another champion has entered the lists in favor of the view that not only is a diet high in protein not harmful to the kidney of the particular experimental animal, but that a pure amino-acid, cystine, said by some to cause nephritis, does not produce nephritis.

Addis, MacKay and MacKay* have approached this question after a very careful study of the literature. They call attention to many errors in previous experiments, the chief of which is that the diet fed to the white rat must be one which of itself is adequate for nutrition and normal growth and which is changed only in the addition of one element. The controls must be carefully watched. When all conditions have been fulfilled then conclusions will have some value.

They fed their rats for a period of a year which in the rat's life is the equivalent of 30 years of a man's life. The control diet contained 17.3 per cent protein, the experimental diet contained 69.5 per cent protein. On this latter diet the rats grew but were not quite as heavy as the controls. No evidence was found in the urine of kidney injury throughout the experiment and the kidneys, postmortem, were slightly enlarged over those of the controls, but were in no way damaged. The lessened weight of the rats was found to be due to the lessened amount of abdominal fat.

These experiments confirm the findings of others in the same work. They cannot explain the positive findings of some authors. The reading of this article carried more conviction than any article on this question which the writer has read. The weight of evidence is certainly upon the side of those who deny the harmfulness of protein to the kidney and confirms much clinical observation upon the harmlessness of a reasonable amount of protein in the diet of the nephritic. As a matter of fact there is one malady characterized by enormous amounts of albumin in the urine where a diet rich in protein is absolutely essential in order to prevent depletion of the body proteins. This is lipoid nephrosis, a rather rare disease, but as an addition to glomerular nephritis quite common.

Old ideas have a peculiar tenacity which is only broken down by constant repetition of the new facts. Such a careful piece of research as this by Addis and his co-workers should help materially to shatter ancient belief in the danger of feeding proteins to nephritics.—*L. M. W.*

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*Addis, T., MacKay, Eaton M., and MacKay, Lois Lockard: The effect on the kidney of the long continued administration of diets containing an excess of certain food elements. I. Excess of protein and cystine. Jour. Biol. Chem., 71:139, 1926 (Dec.).

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SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

The Brown-Kewaunee County Medical Society held their March meeting at the Hotel Northland, Green Bay. From five until six o'clock Dr. Robert B. Preble of Chicago conducted a heart clinic in which cases of diseases of the heart were presented and discussed by Drs. Wochos, Saunders, Burdon and Muehlhauser. After this very interesting hour, a dinner was served, which was also attended by doctors from Appleton and Marinette.

Before the evening program Dr. J. B. MacLaren, president of the Outagamie County Medical Society, was introduced and invited the members of the local society to their meeting on April 19th. Dr. C. D. Neidhold, Outagamie county secretary, spoke on the x-ray bill, after which Dr. J. R. Minahan, Green Bay, made a motion which was seconded and carried that the Brown-Kewaunee county secretary write their senator and two assemblymen as being opposed to the bill.

Dr. Preble then spoke on "Handling of the Cardiac," which was very interesting and constructive. The meeting adjourned at 9:30 o'clock.—*M. H. F.*

DANE

The March meeting of the Dane County Medical Society was a joint meeting with the Staff of the Madison General Hospital, at the Madison General Hospital. The scientific program was as follows: Drs. R. T. Cooksey and L. V. Littig "Acute Myelogenous Leucemia with Case Presentation." They recommended x-ray and radium as a treatment of choice and their patient had shown a very good remission. The paper was discussed by Drs. Medlar and Joseph Dean. Second, Dr. H. P. Greeley, "Increased Metabolic Reading without Hyperthyroidism." The greatest importance are clinical findings while metabolism is just an aid in arriving at a correct diagnosis; discussed by Drs. A. Jackson, Severinghaus, Hodges, and Lindsay. Third, Dr. T. W. Tormey, "Acute Abdomen." The excellent presentation of this important problem brought on a very interesting discussion by Drs. E. Schmidt, Joseph Dean, Stovall, A. Jackson, N. Nelson, and Sheldon, Sr.

A committee for the medical care of the poor was appointed, consisting of Dr. H. P. Greeley, chairman, Drs. Head, Fauerbach, Falk and Bilstad.

A committee was appointed to look after the nursing problem in Dane county consisting of Dr. A. Sullivan, chairman, and Drs. Hodges, Lindsay, Brown and N. Nelson.

The April meeting was a joint meeting with the staff of the Wisconsin State General Hospital at the Wisconsin State General Hospital. The scientific program was as follows: Dr. R. E. Burns, "Presentation of Cases"; Dr. W. F. Middleton, "Minet's Diet in Pernicious Anemia." This paper gave a résumé of the results obtained at the University Hospital with Minet's Diet. The clinical remissions are outstanding in comparison of former treatment. Dr. Middleton demonstrated the food trays of such a diet and showed on charts the improvement of the blood picture. Dr. A. Ochsner, "Operative Treatment of Subphrenic Abscess" and Dr. J. E. Gonce, "Infant Feeding."—*H. H. R.*

DOUGLAS

At the regular monthly meeting of the Douglas County Medical Society, held on April 6th, the society was addressed by Dr. T. G. Clement of Duluth, Minn. The title of Dr. Clement's paper was "The Physiological Effects of Diathermy in Certain Pathological Conditions."

The members of the Douglas County Society were guests of the St. Louis County (Minnesota) Medical Society on April 8th. The speaker of the evening was Dr. Allen K. Krause of Johns Hopkins University, his subject being "Trends in the Treatment of Tuberculosis." —*J. W. McG.*

EAU CLAIRE

The Eau Claire & Associated Counties Medical Society met at the Eau Claire Hotel on March 28th. There were thirty-one present and the speakers of the evening were Dr. G. Elmer Strout, of the University of Minnesota, Minneapolis, who spoke on "Conservation of Vision," and Dr. F. S. Cook, Eau Claire, who presented a paper on "Hemorrhagic Mastoiditis with Report of Three Cases."—*H. M. S.*

GREEN

The members of the Green County Medical Society met on April 26th at the Hotel Ludlow, Monroe. The following program was presented: "Cystoscopy," by Dr. G. K. Woolf, Janesville; "Avulsion of Scalp," by Dr. T. W. Nuzum, Janesville; "Backache," by Dr. Herman Schumm, Milwaukee; "Infant Feeding," by Dr. J. E. Gonce, University of Wisconsin, Madison; "Treatment of Chronic Nose and Throat Condition," by Dr. W. M. Nesbit, University of Wisconsin, Madison.

Officers for the ensuing year were elected and include: President, Dr. Edward Blumer, Monticello; Vice-President, Dr. W. B. Gnagi, Monroe; Secretary-Treasurer, Dr. J. F. Mauermann, Monroe. Delegates to state meeting are Dr. J. F. Mauermann and Dr. W. B. Bear as alternate.—*J. F. M.*

MANITOWOC

The Manitowoc County Medical Society held a dinner meeting Thursday, April 14th, at the K. C. Club rooms, Manitowoc. The meeting was well attended. Dr. Otho Fiedler of Sheboygan addressed the society on "Hypertensive Heart Disease." Different aspects of the subject were discussed by Drs. Eigenberger, Stannard, Turgasen, Gleason and Farrell. Mr. Finn, who is in charge of the Holy Family Hospital building fund drive, made a short appeal for united moral support of the society members in the proposed effort to raise a half million dollars for additions to the hospital.

After discussion and motion, a committee consisting of Drs. MacCollum, Andrews, and Shimek, was appointed for the purpose of conferring with the high school officials in regard to a plan for the annual examination of entering high school boys, plans being on foot for a more systematic and effective course of physical training by the physical director.

On motion a committee composed of Drs. Gleason, Hammond and Farrell was appointed to make a survey of the local nursing situation, and to cooperate with the state society efforts in consideration of the problems relating to same.—*M. P. A.*

MARATHON

Members of the Marathon County Medical Society and of the Marathon County Dental Society held their first joint meeting of the year on March 30th at the Wausau Club, when almost one hundred local surgeons, physicians, dentists and members of the profession from outside the city attended the 6:30 o'clock dinner and the session later in the evening.

Lectures and discussions on topics of interest to members of all the professions represented were the features of the evening's program. The first lecture on the program was a talk by Dr. John A. Frey on "Routine Examination of the Teeth and Gums," and the discussion on the subject was led by Dr. J. H. Kolter. Dr. Joseph F. Smith was next on the varied program with a talk on "Tumors of the Mouth," followed by a general discussion by members of both societies. "The Devitalized Tooth" was the topic of Dr. D. C. Prehm and Dr. W. D. Siebecker led the discussion. Dr. J. M. Freeman lectured on "Mouth Infection" and this, as were the others, was discussed at length.

All of the talks were interesting and the doctors were in unison in declaring that joint meetings of the two county societies should be held more often because of the general knowledge gained.—*V. E. E.*

MARINETTE-FLORENCE

Dr. R. C. Blankinship and Dr. E. L. Sevringhaus of the Wisconsin General Hospital, Madison, were guests of the Marinette-Florence County Medical Society at its regular dinner-meeting held on April 28th. Dr. Blankinship gave an illustrated lecture on "Colitis" and Dr. Sevringhaus spoke on "Diets." There were twenty-six physicians present coming from Stephenson, Daggett and Menominee, Michigan, Green Bay and Oconto, Wisconsin. The meeting was one of the best in our history.—*M. D. B.*

KENOSHA

Dr. Arthur W. Rogers, Oconomowoc, president of the State Medical Society, was the speaker at the regular meeting of the Kenosha County Medical Society, held on April 19th at the Elks' Club. He gave an address full of helpful suggestions on the subject of "How To Keep Well."

Another talk on the same topic was given by Dr. Frank Pope of Racine, who stated that a constant state of health is best attained by the periodic health examination. Following the business session and the two addresses, the physicians adjourned for a social hour and luncheon was served.—*H. A. B.*

OUTAGAMIE

The April meeting of the Outagamie County Medical Society was held on April 19th. Dr. Henry B. Thomas of Chicago held an orthopedic clinic at the Vocational School from 3:00 to 5:00 in the afternoon. This clinic was held in conjunction with the work of the Wisconsin State Rehabilitation Commission and about twenty-five crippled children were examined and advised.

The evening meeting was held at the Hotel Conway and following a dinner, Dr. Thomas addressed the society on "Some Interpretations of Orthopedic Surgery." There were about sixty members from the Outagamie Society and neighboring societies present. It was a very interesting and instructive meeting—*C. D. N.*

SHEBOYGAN

The members of the Sheboygan County Medical Society met at the Association of Commerce rooms on April 5th. Dr. L. M. Warfield, Milwaukee, gave an interesting talk on "Encephalitis" and held a heart clinic following the banquet.—*G. J. J.*

RACINE

The members of the Racine County Medical Society met at St. Mary's Hospital, Racine, on Thursday, April 28th. Dr. F. W. Pope, Racine, spoke on "Periodic Health Examination for the Apparently Healthy" and Drs. W. C. Roth and H. B. Keland presented clinical cases.—*S. J.*

WAUKESHA

Physicians at Resthaven, members of the Waukesha County Medical Society, entertained the organization at the Veterans' Hospital during April. The hosts included: Drs. F. J. Woodhead, W. H. Oatway, J. C. Rodger, J. W. Visher and C. W. Rhea. The meeting was featured by a scientific program, the symposium of which related to chronic gastro-intestinal disturbances. Dr. Rhea presented a chemical history with laboratory findings. Dr. Stevens, Milwaukee, discussed the same subject in conjunction with Dr. Rhea. "Gross Methodology and Surgical Treatment" was the subject of Dr. Woodhead's paper.

An interesting round-table discussion followed the presentation of papers. Before the close of the meeting a banquet was served in the dining room of the hospital.—*J. F. W.*

MILWAUKEE ACADEMY

At the meeting on April 12th of the Milwaukee Academy of Medicine, Dr. J. M. King presented a case report, Dr. N. W. Bourne spoke on "Treatment of Gonorrhea in the Male," and Dr. Solomon Strouse, Chicago, presented a paper on "Obesity as a Practical Problem in Therapeutics."

Gifts of books and periodicals have been received from Drs. Carson, Beebe, Ogden, Henes and Taylor; Drs. Thalhimer and Tharinger have contributed toward the building-up of the pathological section in the library; and other gifts have been presented by Drs. Echols and Sargent. Through the generosity of Mrs. W. A. Becker, Dr. Becker's library is now permanently housed in the Academy library and known as the W. A. Becker Memorial Collection.

The April 26th meeting was also held at the Academy Library in conjunction with the Neuro-Psychiatric Society. Dr. Peter Bassoe, Chicago, professor of Neurology at Rush Medical College, spoke on "Neurological Aspects of Brain Tumors" and Dr. Walter Dandy, of the Surgical Department of Johns Hopkins Hospital, Baltimore, Md., gave a paper on "The Surgery of Brain Tumors."—*D. E. W. W.*

MILWAUKEE OTO-OPHTHALMIC

The regular meeting of the Milwaukee Oto-Ophthalmic Society was held on Tuesday evening, April 19th, at the

University Club. A dinner preceded the following program: "The Static Apparatus in Barrany's Work" by Dr. Frank Pfister; "Choanal Atresia" by Dr. William E. Grove, and "Deformities of the Teeth and Jaw and Their Relation to Rhinology" by Dr. A. C. Rhode.

—*E. R. R.*

UNIVERSITY OF WISCONSIN

The fourth of a series of talks by members of the clinical preceptorial staff of the University of Wisconsin Medical School was presented by Dr. F. Gregory Connell, Oshkosh, on "Indirect Inguinal Hernia," at the meeting held in Science Hall on April 21st. Dr. E. M. Medlar and Dr. G. J. Kastlin gave an interpretation of "Blood Picture in Tuberculosis Based on Pathology of the Disease." A further report of the work inaugurated by Dr. Medlar on the significance of the reaction to tuberculosis.

Dr. C. D. Leake spoke on "Historical Development of Medical Ethics: VI. Percival's Code."—*C. D. L.*

NEWS ITEMS AND PERSONALS

Dr. J. A. Bigler and wife, La Crosse, are at St. Louis where Dr. Bigler is doing post-graduate work in Pediatrics at Washington University.

Dr. Paul C. Hodges, who for the past few years has been roentgenologist at the Union Medical College, supported by the Rockefeller Foundation at Pekin, China, will leave there June 1st to become professor of roentgenology at the University of Chicago. Dr. Paul Hodges is a brother of Dr. Fred J. Hodges of Madison.

Friends and relatives of Dr. Philip R. Fox, Sr., gathered recently at his home in Madison to celebrate his 87th birth anniversary. Dr. Fox was in active practice until about six years ago.

Dr. Wallace W. Coon, Gays Mills, expects to establish his practice at Milton about June 1st. Dr. Coon specializes in obstetrics and children's diseases.

The Wisconsin Alpha chapter of Alpha Omega Alpha, national honorary medical fraternity, held an initiation recently at the home of Dr. W. A. Mowry, Madison. Dr. Joseph S. Evans, chief physician at the Wisconsin General Hospital and professor of medicine at the University, was initiated as an honorary member. Among Madison alumni present were: Drs. W. A. Mowry, C. R. Bardeen, Robert Van Valzah, Alton Ochsner, Albert Tormey, H. P. Greeley, E. C. Stiehm, F. A. Davis, E. U. Neff, R. L. Bower, F. J. Hodges, E. R. Schmidt and C. H. Bunting.

The Biennial Conference of Health Officers will be held at Eau Claire the week beginning September 20th and will be given over to a public health program for health officers, consisting of addresses upon public health topics of joint interest to health officers and physicians.

The American Heart Association has now become the Heart Committee of the National Tuberculosis Association.

Dr. E. R. Schmidt, chief surgeon of the Wisconsin General Hospital, Madison, sailed March 30th on the "President Harding" to attend the German Surgical Congress at Berlin. Before his return the latter part of May, Dr. Schmidt will visit a number of the German clinics.

Dr. W. L. Johnson has severed his connections with the Munn-Farnsworth clinic, Janesville, having purchased the equipment and records of the late Dr. F. R. Lintleman. Dr. Johnson will occupy the offices of Dr. Lintleman on the third floor of the Hayes block. He specializes in diseases of the eye, ear, nose and throat.

Combining the old time strolling minstrel with the once popular Punch and Judy show, the Wisconsin Anti-Tuberculosis Association has originated a unique method of teaching health truths and health habits which is proving very popular in Wisconsin schools. Besides appearing in the school rooms of the state, the modernized performance is also given before parent-teacher associations and similar groups and it is said that adults find it fully as enjoyable as the children do. The playlet was written by a staff member of the association, Mrs. Louise F. Brand, Milwaukee.

Dr. F. E. Kosanke, formerly of Watertown, has announced the opening of a suite of offices at Fond du Lac about May 10th. He plans to establish a general practice, including physical therapy.

Dr. John E. Mulsow addressed the Mothercraft Class of the Maternity Hospital and Dispensary Association, Milwaukee, on April 8th. His subject was "The Care of the Eye."

Dr. and Mrs. Sigurd Gundersen of La Crosse left the latter part of April for travel in Europe. During their absence they will visit in England and France and devote special attention to Norway, visiting the old home of Dr. Gundersen's mother. Later in the season they will probably be joined in Paris by Miss Eleanor Head, Madison, who is teaching this year in Italy.

Dr. W. W. Bauer, who has served as health officer at Racine for the past three years, has tendered his resignation to the board of health. Acceptance of a position as a member of the staff of the Wisconsin Anti-Tuberculosis Association caused Dr. Bauer to leave the employ of Racine. The doctor came to Racine in 1923. Before that he was director of the bureau of contagious diseases for the Milwaukee Health Department.

One of the best investments that an industrial concern can make is to have each employee undergo a complete physical examination, declared Dr. B. H. Oberembt, Milwaukee, in an address before the Wisconsin Nurses' Club recently.

Dr. Jerome R. Head, son of Dr. L. R. Head, Madison,

has just announced the opening of an office at 122 South Michigan Ave., Chicago. Besides carrying on a private practice, Dr. Head is also an instructor in surgery at the University of Illinois and an assistant in surgery to Dr. Carl Hedblom at the Augustana Hospital. Dr. Head is a graduate of Harvard Medical School and before going to Chicago was for two years assistant surgeon at the State of Wisconsin General Hospital at Madison.

The average length of life of Milwaukeeans in 1870 was only 18 years, unbelievable as it may sound, Dr. E. V. Brumbaugh of the Milwaukee Health Department, told social workers, teachers and parents at the Journal Building Auditorium recently. He explained that the figure was due to an infant mortality of 30 per cent in the first year after birth. The average life of Milwaukeeans last year had been raised nearly to 46 years.

An address was also given by Dr. George Barth, of the health department, who emphasized the need of strict medical attention for the pre-school age child.

Dr. C. O. Decker, of Crandon, was elected mayor of that city during a recent election.

Dr. W. N. Nolan, Kaukauna, has resigned as city physician and will devote his entire time to private practice. Dr. Nolan has served in this capacity for a period of about twenty years.

Dr. A. C. Borchardt, who recently had a serious operation, is again able to resume his duties at the office.

Dr. Vernon A. Chapman, Colby-Abbot Building, Milwaukee, announces that he has associated with him Dr. T. E. Briant of New York City. Dr. Briant was a graduate of the University of Toronto in 1923 and following a period as ship surgeon on the Leviathan, was the resident surgeon in the eye, ear, nose and throat at New York Polyclinic.

An exhibit case has been built in the lobby of the State of Wisconsin General Hospital. It is planned to arrange monthly exhibits of general medical interest in this case and to make them of non-technical character so that visitors to the Hospital may find them of interest.

The first exhibit placed in the case was a collection of photographs and original articles relating to Lord Lister. This was arranged in connection with the world-wide celebration of the centenary of Lister's birth April 5, 1827.

In connection with the graduation of the first class in medicine from the University of Wisconsin, a special exhibit of important contributions to medicine made by Wisconsin men will be placed on display.

The condition of Dr. Arnold S. Jackson of the Jackson Clinic, Madison, who is confined at the East Washington Hospital with scarlet fever, has been reported as greatly improved.

Dr. R. C. Buerki, superintendent of the State of Wisconsin General Hospital, Madison, spoke before a recent luncheon meeting of the Menasha Rotary Club. The subject of his address was "The State of Wisconsin General Hospital and Its Relationship to the State." The Neenah Rotary Club and physicians of the twin cities were invited to join with the local Rotarians at the meeting.

The health committee of the Oshkosh board of education, of which Dr. E. F. Bickel is chairman, met recently to discuss the sanitary conditions of Oshkosh school buildings. Each school physician has been requested to submit a brief report for his building, together with whatever recommendations he may deem necessary.

The school physicians and the schools they serve are: Dr. Burton Clark, Jr., Park School; Dr. J. M. Conley, Dale School; Dr. J. W. Lockhart, Franklin School; Dr. H. J. Haubrick, Jefferson School; Dr. S. M. Keyes, Roosevelt School; Dr. H. H. Meusel, Longfellow School; Dr. John F. Schneider, Read School; Dr. G. A. Steele, Merrill School; Dr. J. F. Stein, Washington School, Dr. W. A. Wagner, Smith School; and Dr. W. P. Wheeler, Lincoln School.

At the recent meeting of the Federated American Societies for Experimental Medicine at Rochester, N. Y., Dr. W. J. Meek, of the University of Wisconsin Medical School, was reelected secretary of the American Physiological Society. This is the third time this honor has been given Dr. Meek.

The share of Beloit College in the estate of the late Dr. Walter S. Haven, Racine, brought an income to the college this year of $4,591, it has been announced at the treasurer's office.

Of this amount $2,000 is being expended in scholarships this semester for worthy students; $500 goes to the science department for student aid or for equipment; and the remainder will be paid out next fall in scholarships.

Dr. E. P. Crosby, Stevens Point, has sufficiently recovered to answer professional calls and attend to his practice in general. The doctor sustained an injury last fall which resulted in supperative arthritis, disabling him for a period of seven months.

Dr. Gerald K. Wooll, Janesville, spoke before the St. Mary's Parent-Teacher Association recently. His subject was "Narcotics."

"The greatest desire of man as far back as history goes to the present time, is to live as long as possible free from pain and misery, and to live as happily as possible," said Dr. Charles H. Mason in his recent talk on "Romance of Medicine" before members of the Superior Kiwanis Club. Dr. Mason suggested that as one takes his car to have it overhauled every year, so should he take his body to his medical adviser once a year for thorough examination.

French Lick Springs Hotel, Indiana, is now in midseason, with horseback riding, golf, and other recreations vying with each other in popularity. Many visitors go

to French Lick for the mineral waters that abound there in the region so well known as the "Lost River Valley." It is a picturesque as well as an historical section about which books have been written. But the healthful climate and the mineral waters continue to be the chief attraction for thousands of visitors each year. The beautiful gardens and surroundings of French Lick Springs Hotel bespeak the peaceful and healthful atmosphere which prevails there. The percentage of illness is considerably less there than in other cities, towns, and villages of Indiana. Still the authorities provide for those who may be sick. Dr. A. H. Harold, an experienced physician of Indianapolis, has recently accepted the position as Medical Director at French Lick Springs Hotel.

DEATHS

Dr. Edwin C. Jacobs, Durand, died at his home on March 25th. He had been in poor health for several years and his death was not unexpected. Dr. Jacobs was born in Milwaukee July 18, 1865, and attended Rush Medical College, Chicago, and the Kentucky School of Medicine at Louisville, from which he was graduated in 1892. He served his internship at Cook County Hospital, Chicago, and at the Northern Illinois Penitentiary at Joliet.

Dr. Jacobs practiced medicine in Milwaukee for several years and later became associated with the Hospital for the Insane at Oshkosh. He established his practice at Durand in 1895 and remained there until the time of his death, occupying the same office rooms during all of that period.

The deceased was a member of the Eau Claire County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his aged mother, three brothers and three sisters.

Dr. Walter A. McEachern, Superior, died on March 31st following a cerebral hemorrhage. Dr. McEachern was born in Porters Mills, September 5, 1873, and attended the Superior public schools. Following graduation from the Blaine high school, he attended the school of engineering. He later attended Rush Medical College at Chicago and the Medical School of the University of Minnesota. In 1896 he moved with his parents to Sandstone, where several years later he began his practice of medicine. He returned to Superior in 1914 and resided there since that time. The deceased was one of the first Superior physicians to enter the service during the World War and one of the last to return.

Dr. McEachern was a member of the Douglas County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. Surviving him are his wife, a son and a daughter.

Dr. Henry Johnstone Weld, Campbellsport, died at his home on April 4th following an illness of two years. Dr. Weld was born in the year 1867 and was graduated from the Detroit College of Medicine and Surgery in 1895. The deceased served as president of the village of Campbellsport for two years and was its health officer for a number of years.

Dr. Simon C. Keller, Sauk City, died following a cerebral hemorrhage on March 21st. Dr. Keller was born in Sauk City on June 21, 1879. He taught in rural schools of Sauk county a number of years and in 1903 was graduated from Rush Medical College, Chicago. After finishing at Rush he went to Elkhorn, where he practiced medicine for about a year, then coming to Sauk City, where he followed his profession and resided until death.

Dr. Keller was formerly a member of the Sauk County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his parents, his wife and a son.

Frederick Belding Power, Ph.D., internationally known chemist and for the past ten years head of the Phyto-Chemical Laboratory of the Bureau of Chemistry, Department of Agriculture, died at his residence in Washington, Saturday, March 26th.

He was a graduate of the Philadelphia College of Pharmacy in 1874. He received the degree of "Ph.D." at the University of Strassburg in 1880 and returning to this country served for several years as Professor of Analytical Chemistry at the Philadelphia College of Pharmacy. He was also Professor of Pharmacy and Materia Medica at Wisconsin University from 1883 to 1892.

Dr. Power's most important contribution to science was his research work at the Wellcome Chemical Research Laboratory, London, England, where he served as director from 1896 to 1914, during which time he isolated and identified the principles of the oil of the chaulmoogra tree of southeastern Asia which is now so universally used as specific treatment in the cure of leprosy.

In cooperation with Professor Roger Adams of the University of Illinois, Dr. Power was co-inventor in the development of synthetic process for the manufacture of chaulmoogra oil. This process greatly aids the fight to stamp out leprosy because it makes available a steady and certain supply of synthetic oil of chaulmoogra whereas before physicians were obliged to depend upon the rare and uncertain supply from the natural source, the chaulmoogra oil tree.

Dr. Power was the recipient of many medals for pharmaceutical and chemical research. In 1922 he received the Flueckiger gold medal. In 1914 he was awarded a gold medal by Mr. Henry S. Wellcome, founder of the Wellcome Chemical Research Laboratory in London, in recognition of his distinguished service to science.

Dr. Power was born 74 years ago at Hudson, N. Y., where the interment was held on April 1st. He is survived by two children, a daughter, Mrs. Annie Louise Heimke, and a son, Donald Meigs Power.

Dr. L. W. Sayles, Baraboo, died on April 11th at the Wisconsin General Hospital, Madison. Dr. Sayles was born in the year 1869 and was graduated from Rush Medical College, Chicago, in 1893. The doctor practiced medicine at Baraboo for more than twenty years, served several terms as health officer of that city, and also as captain in the medical corps during the World War.

Dr. Sayles was a member of the Sauk County Medical

Society, the State Medical Society of Wisconsin and the American Medical Association. Surviving him are his wife and daughter.

Dr. Arthur H. Broche, Oshkosh, died at his home Monday, April 11th, of lobar pneumonia. Dr. Broche was born at Milwaukee, Nov. 20, 1875. His early education was obtained in the public schools of Milwaukee and in 1896 he was graduated from the Milwaukee Medical College. Following his graduation he began the practice of medicine at Winneconne, later coming to Oshkosh, where he served as city health officer for many years.

The deceased is survived by his wife and his mother. He was a member of the Winnebago County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Dr. Samuel B. Buckmaster, Delavan, died Saturday morning, April 16th, at Mercy Hospital, Janesville. Dr. Buckmaster was born in Lima, Ohio, April 26, 1853, and was graduated from the medical department of the University of Virginia in 1879. In 1880 the physician received the appointment as assistant at the State Hospital for Insane at Madison. Four years later he was chosen as superintendent of the State Hospital, a position he held for ten years. Dr. Buckmaster was formerly a practicing physician in Janesville and served as commissioner of health for a period of six years. Since his retirement, the deceased has resided with his daughter at Delavan. He is survived by his wife and three daughters.

CORRESPONDENCE

X-RAY FILMS

AMERICAN MEDICAL ASSOCIATION
Bureau of Legal Medicine and Legislation
William C. Woodward, M.D., LL.M., Executive Secretary
535 North Dearborn St., Chicago

April 6, 1927.

Mr. J. G. Crownhart, Sec.,
State Medical Society of Wisconsin,
153 E. Wells St.,
Milwaukee, Wis.

Dear Mr. Crownhart:

Your letter of March 31st has been received, submitting inquiries received by you from a correspondent relative (1) to the right of a physician to withdraw his x-ray films from the hospital without the permission of the hospital authority, and (2) to the length of time a hospital should keep such films on file.

For the purpose of answering your correspondent's inquiry, I assume that the roentgenograms referred to were made in the hospital in connection with the treatment of a patient in the institution, and at the expense of the patient. I assume further that the physician in connection with whom this inquiry arises is the physician in attendance on the patient, in his private capacity and not a physician in the service of the hospital, either as a roentgenologist or otherwise.

1. *Ownership of x-ray films.* Ordinarily, hospitals require that records compiled in connection with the treatment of patients in the institution remain in the hospital. Patients who avail themselves of the facilities a hospital offers and physicians undertaking the treatment of patients in a hospital impliedly agree to abide by the rules and customs of the institution. If a patient desires to have the benefit of the hospital's facilities, or if a physician desires to treat a patient in a hospital, on any conditions other than those determined by the rules and customs of the institution, an understanding to that effect should be arrived at before the patient enters the hospital.

In the present instance, then, unless the rules and customs of the hospital provide otherwise, and if they do not, unless the patient or the attending physician has expressly bargained otherwise, I cannot see on what ground a physician can claim the right to remove roentgenograms of his patient from the hospital, any more than he could claim the right to remove temperature charts, records of urinary analyses, records of blood counts, etc. They are all a part of the records of the hospital and, in my judgment, the hospital is entitled to keep them, subject to such rights as the patient may have in them.

Inasmuch as the physician in the assumed case did not pay for the making of the roentgenograms, it is difficult to see on what ground he could claim any interest or ownership in them. The exact nature and extent of the interest and ownership of the patient who did pay for them is not so clear. I can find no record of the matter ever having been determined by any court of last resort, and I have never heard of it having been determined in any other court. If the question should ever arise, I am inclined to think that the courts might hold that a patient was entitled to inspect the record of his treatment in a hospital, including roentgenograms forming a part of that record, and to have that record inspected on his behalf. It is not unlikely, too, that the court might hold that a patient was entitled to a copy of the record, if necessary for the patient's welfare, at least on payment of the cost of making a copy. These, however, are mere surmises on my part.

The Radiological Society of North America, at its meeting in Chicago in 1920, adopted a resolution expressing the judgment of the Society that all roentgenograms, plates, films, negatives, photographs, tracings, or other records of examination are the exclusive property of the radiologist who made them or of the laboratory where they were made.

2. *Length of time hospital records shall be kept.* So far as I have been able to discover, there is no statutory requirement in Wisconsin with respect to the length of time a hospital must preserve its records. As a general rule, I should say they should be preserved just as long as the storage facilities of the hospital will allow. A hospital seems to me to be under a moral obligation, although not under a legal obligation, to maintain storage facilities that will enable it to keep all records that may by any reasonable probability be involved in litigation until after the expiration of the period within which such litigation may be instituted and if such litigation has been instituted, then until the termination of that litigation. Inasmuch as it is difficult to segregate

the records of those cases that may give rise to litigation from the records of those that may not, the only safe rule seems to be, then, to preserve all records for the period stated above.

Possibly an exception may be made in connection with records of the treatment of minors, where the minor may institute action on attaining his majority, or within a stated period thereafter. It would doubtless be held unreasonable to expect a hospital to preserve records in all cases for so long a period as might be necessary with respect to some cases of minors. If, however, a hospital had reasonable ground for believing that the records in the case of any particular minor might be needed, there is no reason why they should not be segregated from the other records and preserved.

I am sorry I cannot give you categorical answers to the questions your correspondent propounded. The fact that such questions have never been carried to courts of last resort is strongly suggestive, however, of the idea that they are usually settled on the basis of equity and common sense—which, after all, is the best way to settle them.

Yours truly,
(Signed) Wm. C. Woodward,
Executive Secretary,
Bureau of Legal Medicine
and Legislation.

WCW:RR

SUMMER CLINICS

CHICAGO MEDICAL SOCIETY
25 East Washington Street
Chicago

April 1st, 1927.

Dear Sir:

Would you kindly favor us by giving the enclosed announcement of the Summer Clinics to be held in Chicago, June 13th to July 8th, 1927, publicity in your medical journal?

We are very anxious to have the Summer Clinics well attended and appreciate the co-operation you may give us.

Very truly yours,
CHICAGO MEDICAL SOCIETY,
Per R. R. Ferguson, President.

RRF*G

CLINICS, CHICAGO, 1927

Announcements and schedules will soon be ready for the 1927 Summer Clinics of the Chicago Medical Society, supported by many of the largest hospitals in the city, among them being the Post Graduate Hospital, Chicago Memorial Hospital, University of Illinois College of Medicine, Cook County Hospital, Michael Reese Hospital, Mercy Hospital, Presbyterian Hospital, Jackson Park Hospital, St. Luke's Hospital, Ravenswood Hospital, Mount Sinai Hospital, Francis Willard Hospital, West Suburban Hospital, Evangelical Hospital, North Chicago Hospital, Chicago Lying-In Hospital, St. Joseph's Hospital, Alexian Brothers Hospital, Laboratory of Surgical Technique, Washington Park Hospital, Jackson Park Hospital, Chicago Municipal Tuberculosis Sanatorium, and John B. Murphy Hospital. Several of our large laboratories have also agreed to co-operate with us in this great work.

In 1926 we limited registrations to physicians living in Illinois, but our increased facilities make it possible to accommodate many more than last year. Registration therefore will be open to physicians from other states and to as many as may be accommodated, in the order of their registration. Registration fee will be $10 for each two weeks' course, payable at time of registration, and a physician may register for only one course of two weeks.

Admission will be by card only, issued by the Chicago Medical Society and no registration card will be issued until registration fee is paid.

The first two weeks' course will begin on Monday, June 13th, 1927, at 9 a. m., ending Friday, June 24th.

The second two weeks' course will begin on Monday, June 27th at 9 a. m., ending Friday, July 8th.

This is an excellent opportunity for the medical men of the country to obtain real post graduate work in some of the best hospitals in the world, and from some of the best clinicians found anywhere.

Schedules will be sent to the 10,000 physicians in Illinois, and announcements will be sent to the American Medical Association, and the several state medical journals.

We will probably be unable to accommodate all those desiring this wonderful clinical course, so it behooves those in Chicago and Illinois to register early if they desire to take advantage of this year's summer clinics. Last year our registration closed one week after the first announcement.

MEDICAL ETHICS

AMERICAN MEDICAL ASSOCIATION
Council on Medical Education and Hospitals
535 North Dearborn Street, Chicago

March 16, 1927.

Mr. J. G. Crownhart, Sec.,
State Medical Society of Wisconsin,
Milwaukee, Wis.

Dear Mr. Crownhart:

At the meeting of the Board of Trustees of the American Medical Association held in November, 1926, a recommendation was adopted expressing the hope that the Council would "undertake to have lectures on medical ethics made a part of the curriculum in every approved medical school. This matter was taken up at the business meeting of the Council on February 13, 1927, and the following report was unanimously adopted:

"The Council on Medical Education and Hospitals of the American Medical Association recommends that adequate instruction in the traditions and principles of medical ethics be included in the required curriculum of all medical students. While realizing that the subject is now touched upon in all schools, and that its principles can be inculcated by example, yet the Council believes that detailed and sympathetic explanation of the 'Principles of Medical Ethics,' as formulated by the American Medical Association, should be the minimum of the formal instruction given in medical schools.

"The Council suggests also that the subjects of medical economics, medical jurisprudence, medical history and perhaps also in some instances pastoral medicine might be conveniently grouped with that of medical ethics

under the general title of the 'Social Relations of the Physician.'

"The Council recommends also to the American medical profession through its national, state and local organizations that it seek to adequately familiarize its members with the same material suggested for medical students."

With the tremendous increase in the knowledge of medicine and the added complexity in medical practice, including the increasing extent to which hospitals are being utilized for practice, the matter of medical ethics and the importance of maintaining a high degree of integrity on the part of hospital staffs are coming to be more and more important.

Very sincerely yours,
N. P. Colwell, Secretary,
Council on Medical Education
and Hospitals.

NPC:AT

STATE PERMITS

STATE PROHIBITION COMMISSION
Madison, Wisconsin.

April 13, 1927.

Mr. George Crownhart, Secretary,
Wisconsin State Medical Society,
153 E. Wells Street,
Milwaukee, Wisconsin.
Dear Mr. Crownhart:

I wish to call your attention to the fact that a few physicians are operating without a state permit. The law is very plain that any physician using liquor and alcohol or writing liquor prescriptions, must have a state permit and such permit has a fee of ten dollars ($10.00) connected with it. If there are any physicians that have not paid the 1926 fee and used liquor and alcohol, they are still subject to the fee of ten dollars ($10.00) for that year and this will have to be paid before the permit for 1927 can be granted.

We have taken this situation up with the Federal Department and they will refuse to issue a federal permit, or will revoke any permit now outstanding, unless the physician meets the requirements of this office.

We regret very much that the law is such that the physicians who only use alcohol for sterilizing purposes have to pay the fee. Nevertheless, the law is such and until it is changed we will have to enforce it as it stands.*

We hope that we will not have to refuse any permits and assure you that we will try to assist you in every way possible.

Very truly yours,
R. W. Dixon,
State Prohibition Commissioner.

RWD-rt

*Editor's Note—Assembly bill 274A by Peterson, will, if passed, correct this situation. See legislative report for status of this bill.

OFFICIAL CALL

To the Officers, Fellows and Members of the American Medical Association:

The seventy-eighth annual session of the American Medical Association will be held in Washington, District of Columbia, from Monday, May the sixteenth, to Friday, May the twentieth, nineteen hundred and twenty-seven.

The House of Delegates will convene on Monday, May the sixteenth.

The Scientific Assembly of the Association will open with the General Meeting held on Tuesday, May the seventeenth, at 8:30 P. M.

The various sections of the Scientific Assembly will meet Wednesday, May the eighteenth, at 9 A. M. and at 2 P. M., and subsequently according to their respective programs.

Wendell C. Phillips, *President*,
Frederick C. Warnshuis,
Speaker, House of Delegates.

ATTEST:
Olin West, *Secretary*,
Chicago, Illinois, March the seventh.

FREE REVIEW COURSES

Milwaukee, Wis., April 18, 1927.

Mr. George Crownhart,
State Medical Society of Wis.,
153 E. Wells St.,
Milwaukee, Wis.
Dear Mr. Crownhart:

Will you put the following notice in the May Journal:

Members of the staff of the Milwaukee County Dispensary will give two courses of two weeks each during the month of August this year. These courses will be in the morning hours from 9 to 12, two afternoons a week, Monday and Thursday, and one hour one evening a week on Tuesday. They will include General Medicine, Pediatrics, Fluoroscopic Examination, Obstetrics, Neurology and treatment of Syphilis.

As only a limited number of physicians can be accommodated, the application should be sent as soon as possible to the Dispensary, 5th St., and Wisconsin Ave., Milwaukee, Wis. There is no charge for this course. Schedule of hours will be published in the June number of the Journal.

Very truly yours,
MILWAUKEE COUNTY DISPENSARY,
L. M. WARFIELD, M. D.
Clinical Director.

RECIPROCITY LICENTIATES

WISCONSIN STATE BOARD OF MEDICAL EXAMINERS
Office of the Secretary
La Crosse, Wis.

April 20, 1927.

Mr. J. George Crownhart,
153 E. Wells St.,
Milwaukee, Wis.
Dear Mr. Crownhart:

Following is a list of the men who were licensed to practice in Wisconsin on basis of reciprocity at a special meeting of the board held in Milwaukee, Wis., at the Hotel Pfister on April 12-13, 1927:

Herbert Clarence Kimberlin, M.D., 7th Ave., Ashland, Wis., from Nebraska.

Calvin Langdon Longstreth, M.D., Rice Lake, Wis., from Iowa.

George William Rastede, D.O., Green Bay, Wis., from Iowa.

Leslie William Tasche, M.D., Sheboygan, Wis., from New York.

Dean Moorman Veirs, M.D., 202 S. Cleveland Ave., St. Paul, Minn., from Kentucky.

Mark Henry Wall, M.D., St. Mary's Hosp., Duluth, Minn., from Minnesota.

Ralph Milton Waters, M.D., Wis. Gen. Hosp., Madison, from Missouri.

Lester Merrill Wieder, M.D., 1342 Volland St., Ann Arbor, Mich., from Michigan.

Patrick Edgar Wright, M.D., 1573 University Ave., St. Paul, from Minnesota.

Very truly yours,

REF:EH Robt. E. Flynn, M.D., Secy.

COMMISSION ON MEDICAL EDUCATION

215 Whitney Avenue
New Haven, Connecticut

Mr. J. G. Crownhart, Managing-Editor,
Wisconsin Medical Journal,
153 E. Wells Street,
Milwaukee, Wisconsin.

My dear Mr. Crownhart:

Would you mind stating in your publication that we should be glad to supply a copy of the "Preliminary Report of the Commission on Medical Education" to any of your readers who may be interested in the general questions of medical education and practice? We should be glad to supply these copies without charge, and anyone desiring a copy of the report can obtain it by addressing Commission on Medical Education, 215 Whitney Avenue, New Haven, Connecticut.

Sincerely yours,
W. C. Rappleye, M.D.

SOCIETY AID APPRECIATED

WISCONSIN STATE BOARD OF MEDICAL EXAMINERS

OFFICE OF THE SECRETARY

La Crosse, Wis.,
April 18, 1927

Mr. J. George Crownhart
144 Breese Terrace
Madison, Wis.

Dear George:

At the recent meeting of the board held at Milwaukee on April 12 and 13 it was the unanimous opinion of the members that we extend to you and Attorney Wylie a vote of thanks for the splendid assistance and cooperation you have given to us in our legislative program to date.

We want you to know that we appreciate this service very much and to assure you that we shall be glad to reciprocate in any manner possible.

We sincerely hope that Bills 168-S and 239-A will receive favorable consideration in their final hearing as we believe that the Governor will be glad to sign them.

With kind regards, I am

Cordially yours,

ROBT. E. FLYNN,

REF:EH Robt. E. Flynn, M.D., Sec.

SOCIETY RECORDS

NEW MEMBERS

Cummings, J. H., Superior.
Muehlhauser, Jno. O., St. Mary's Hospital, Green Bay.
Daly, F. P., Reedsburg.
Rivord, R. R., Little Chute.
Hypes, F. E., Three Lakes.
Westgate, H. J., Rhinelander.
Torpy, T. G., Minocqua.
Monstad, J. W., Jr., New London.
Konop, Edw. J., Sawyer.
Beadles, C. H., Beloit.
Reuter, M. J., 187—27th St., Milwaukee.
Ozonoff, J. B., 326 Wisconsin Ave., Milwaukee.
Baumgarten, S., 79 E. Wisconsin Ave., Milwaukee.
Greulich, C. D., Sussex.
Tompkins, T. B., Manitowoc.

CHANGES IN ADDRESS

Housley, H. W., Granton, to Neillsville.
Long, D. T., Whitehall, to Menomonie.
Friend, L. J., Merrill, to Beloit.
Kenney, R. L., Mendota, to Wauwatosa.
Dill, Geo. M., Long Beach, Calif., to Prescott.
Gallaher, D. M., Kaukauna, to Appleton.
Kosanke, F. E., Watertown, to Fond du Lac.

Wisconsin spent $1,262,172.11 for the year 1926 under the Aid To Dependent Children's Law. The figures revealed from the State Board of Control's annual audit of the county treasurer's statements show that 5,299 families with 13,762 children were aided. The expense of this mother's pension act is borne entirely by the counties save for the State's appropriation of $30,000 which was pro-rated, not being sufficient to reimburse the counties one-third of the amount they expended, as contemplated by the law.

In the 14 years (1913-1926) Wisconsin has spent a total of $8,117,324.58 caring for 38,804 families with 107,693 children. There are 42 states operating under similar laws, Alabama, Georgia, Kentucky, Mississippi, New Mexico, and South Carolina being the states that have not as yet enacted a law.

The audit further shows that 1,340 new pensions were granted during the year, 2,491 were continued, 174 were increased, 435 decreased and that 859 were discontinued. In 1926 the average family allowance was $23.89 per month and the average allowance per child amounted to $9.23 per month. The causes of the dependency were given as 3,232 widows, 700 husbands incapacitated for work, 617 desertions, 263 husbands in penal institutions, 141 orphans, and 21 children of illegitimate birth.

In the settlement of a local controversy, the State Board of Health advised that it had no record of an authentic case where scarlet fever has been caused or spread through the medium of water.

The biennial conference of Wisconsin health officers will be held at Eau Claire September 20-23, in conjunction with the annual meeting of the State Medical Society. The conference incidentally will mark the fiftieth anniversary of the organization of the State Board of Health.

* * *

"You say that the special investigator of your board has caused a criminal prosecution to be brought against one A at Chippewa Falls for practicing medicine without a license; that the district attorney at Chippewa Falls desires to have an analysis of some black paste that this man is using in his fake cancer work; that A refuses to give up a sample of the paste. You state that you desire to know if there is any provision in the law whereby a search warrant may be issued so that the paste may be secured," declares an opinion of the Attorney General's department.

"The statute providing for the issuing of search warrants is found in Secs. 363.01 and 363.02. None of the provisions there cover a case such as you present. I know of no statutory or constitutional provision which provides for the issuing of a search warrant under such conditions. The man cannot be compelled to produce evidence against himself, and it will be necessary for you to secure the paste from some patient upon whom he has used it."

* * *

"The Blue Book," the official state publication dealing with the history and resources of the state, will be off the press on May 15th and will be furnished free by members of the legislature. Each legislator receives 200 copies of the book to distribute among his constituents. Because of the nature of the valuable material presented in the last volume, the edition was early exhausted. Those desiring a copy of the 1927 book should write to their senator or assemblyman at once for a copy. The book is a compendium of information about Wisconsin. The schools of the state use it as a text book in civics.

* * *

Charles J. Kremer, Milwaukee, was appointed Wisconsin Dairy and Food Commissioner by Governor Fred R. Zimmerman succeeding Harry Kleuter for the term ending the first Monday in February, 1929.

Walter A. Duffy, formerly of Ashland, was appointed Commissioner of Agriculture, for a four-year term, succeeding John D. Jones, Jr.

R. G. Knutson, La Crosse, was re-appointed a member of the state industrial commission for the term ending June 30, 1933.

Dr. William Hausmann, West Bend, was named a member of the state board of dental examiners to succeed Frank C. Babcock, Kaukauna.

* * *

By a majority of 40,000 the voters at the April election approved an amendment to the state constitution under which lands held for forestry purposes may be taxed at a lower rate than other real property. The purpose of the change is to encourage forestry and the conservation of the forests of the state. By a majority of 48,000 the voters defeated a proposed amendment that would increase the salary of members of the legislature from $500 to $1,000 for the biennium.

* * *

Arrangements for the development of one of the largest bass hatcheries in the United States were completed in April by the state conservation commission in the form of a lease of the lowlands and waters of the Trempealeau drainage district along the Mississippi river bottoms opposite Winona. Commissioner Elmer S. Hall announced that the lease made was for a period of ten years. The bass hatchery district comprises 5,500 acres, and of this acreage almost 4,000 can be used for bass propagation purposes. It has a growth of natural food.

* * *

Although Wisconsin has one of the lowest farm tenancy rates in the Union, the percentage of tenancy has been increasing in the last few years, according to Prof. B. M. Hibbard of the University of Wisconsin.

"In 1925 the number of farms in Wisconsin was 193,155 of which 29,936, or 15.5 per cent, were rented," declares Prof. Hibbard. "The number of tenant farms has increased slowly for some years. In 1910 the number rented was 24,654, or 13.9 per cent. In 1920 the number rented was 27,258 and equaled 14.4 per cent. Thus in fifteen years the number of rented farms increased by 5,282; the owned farms increased during the same fifteen years by 16,048. There was an increase in tenant farmers of 21.5 per cent; in owned farms of 9 per cent."

* * *

The Tax Commission rules that where a widow is left a life estate, the inheritance tax must be computed on the whole estate. This commission also informed an attorney that tangible personal property in this state owned by a non-resident is subject to the inheritance tax.

* * *

The attorney general advises that the width of a highway is established by the statutes. He rules also that where children are receiving a mother's pension, the father cannot have his fare paid by the county to and from the hospital.

Attorney general advises commissioner of insurance that automobile insurance which excepts relative of owner from indemnity is illegal.

Teachers' retirement board is advised by attorney general that it should require bond from state treasurer for its securities in his keeping.

* * *

The Department of Public Instruction advises that the teacher or the janitor of a school can be contracted for but one year at a time.

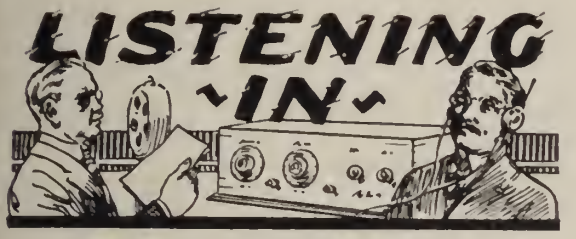
Department of Public Instruction advises that when a school board would elect a member to a teaching post the member should resign from the school board before his election.

* * *

Validity of the Wisconsin water power law is being attacked in the United States Supreme Court. The law empowers the state to purchase at present day values

any water power in the state after it has been used commercially for thirty years. The case at issue involves the taking over by the state of what is known as the middle dam at Appleton.

Whether the state or private interests control basis of water power rights is the issue, according to officials of the state railroad commission. Attorneys for the paper companies which plan to rebuild the dam contend the act takes property without compensation and therefore is unconstitutional.



TWO MORE STATES

Washington and Nebraska have now passed a Basic Science Act. A similar bill is still pending in Minnesota. The two new acts are both modeled on the Wisconsin law. Four states now have this legislation. In order of enactment they are: Wisconsin, Connecticut, Washington and Nebraska.

FROM A. M. A. TRUSTEES

"To promote the establishment of a single standard of professional knowledge and skill for all classes who assume to treat the sick, the Bureau of Legal Medicine and Legislation drafted a form for a basic science act along lines suggested by the acts passed in Wisconsin and Connecticut. This draft was published in the American Medical Association Bulletin in January, 1927, and reprints have been widely distributed. Basic science acts find their justification in the fact that a knowledge of anatomy, physiology, chemistry, pathology, bacteriology and diagnosis is the basis of all rational attempts to heal the sick, no matter what method of healing may be employed, and that the sciences named are securely beyond the reach of dogmas of any healing cult. Basic medical practice acts provide, therefore, for the determining by nonsectarian, nonmedical examining boards of the knowledge of the sciences named, possessed by the applicants who seek licenses to practice the healing art in any form. Applicants who demonstrate to the satisfaction of basic science examining boards' adequate training in such sciences are certified to the proper professional examining boards. Each professional board determines whether the applicants certified to it have the preprofessional and professional education required of practitioners of the particular mode of healing represented by such board. Applicants duly certified by the basic science examining board and having proper preprofessional and professional training are then examined by the professional examining board to determine their professional qualifications. Not until they have been found qualified by the basic science examining boards and the professional examining boards are applicants licensed to practice the healing art in any form. The plan seems calculated to prevent such licensing as is now possible of applicants who are ignorant of even the most elementary principles on which all healing rests."
—Report of Board of Trustees of the American Medical Ass'n., 1927.

ABOLISH STATE REPORTS

Wisconsin's Prohibition Commissioner, R. W. Dixon, reports that he has ordered abandoned the procedure of requiring druggists to make state reports on each prescription containing alcoholic preparations. Mr. Dixon declared this to be a needless duplication of the federal reports and has notified all druggists of the new ruling.

X-RAY FILMS IN HOSPITALS

A Wisconsin hospital asked how long they should keep x-ray films in their records. They were advised while there is no statutory requirement in this respect, such films as a rule should be kept just as long as the storage facilities of the hospital will permit.

"A hospital," declared Dr. W. C. Woodward of the Bureau of Legal Medicine of the A.M.A., "seems to me to be under a moral obligation to maintain storage facilities that will enable it to keep all records that may by any reasonable probability be involved in litigation until after the expiration of the period within which such litigation may be instituted, and if such litigation has been instituted, then until the termination of that litigation."

FILM OWNERSHIP

A second question was asked during April as to the right of a physician to withdraw his x-ray films from a hospital without permission of hospital authority. The Bureau in its answer said:

"Ordinarily, hospitals require that records compiled in connection with the treatment of patients in the institution remain in the hospital. Patients who avail themselves of the facilities a hospital offers and physicians undertaking the treatment of patients in a hospital impliedly agree to abide by the rules and customs of the institution. If a patient desires to have the benefit of the hospital's facilities, or if a physician desires to treat a patient in a hospital, on any conditions other than those determined by the rules and customs of the institution, an understanding to that effect should be arrived at before the patient enters the hospital.

"In the present instance, then, unless the rules and customs of the hospital provide otherwise, and if they do not, unless the patient or the attending physician has expressly bargained otherwise, I cannot see on what ground a physician can claim the right to remove roentgenograms of his patient from the hospital, any more than he could claim the right to remove temperature charts, records of urinary analyses, records of blood counts, etc. They are all a part of the records of the hospital and, in my judgment, the hospital is entitled to keep them, subject to such rights as the patient may have in them."

NARCOTIC COMMITMENTS

A member stated that he had a patient who was addicted to paregoric; that the patient was willing to take treatment, and asked about any provisions for this type of case that the state affords. The Board of Control advised:

"Person may be admitted under the state narcotic

law to our State Hospital for the Insane, as a voluntary case upon his agreement to remain in the institution for a period of six months or longer, if necessary. In the event that the person desires to be admitted as a voluntary case he is to make written application stating his addiction, supported by the certificate of at least two physicians based upon the proper examination of such person. In the event that the patient is admitted voluntarily the cost for her care and treatment must be assumed by relatives. In the event the patient is committed, the cost must of course be paid by her county of residence unless the court shall order that the relatives pay for her care and treatment."

MINNESOTA PASSES LAW

During the closing hours of Minnesota's ninety-day legislative session the basic science bill, proposed by the Minnesota State Medical Association, was given final passage. Minnesota is the fifth state to pass the law.

STORY POPULAR

During April the press service published by the Health Committee of the State Medical Society released a story on Diabetes. So many requests were received from lay readers from all parts of the state for a complete copy of the bulletin referred to in the story, that a special bulletin had to be compiled and mimeographed. The requests were still coming in as this issue went to press.

Résumé and Status of Bills of Interest to Physicians; Assembly and Senate Action to May First Listed

MEDICAL SOCIETIES

88A—McDowell. This bill, introduced by request of the State Medical Society, revises and brings up to date the state law chartering the State Society and county medical societies.

Passed by Assembly. Recommended for passage by Senate Committee on Public Welfare. Passed by Senate. Signed by Governor.

AFFECTING MEDICAL PRACTICE

274A—Petersen. The present law provides that dentists may secure alcohol for the purpose of sterilizing their instruments without payment of a permit fee. This bill extends the same privilege to physicians and veterinarians.

Recommended by Assembly Committee on Public Welfare. Advanced by Assembly. Recommended by Joint Committee on Finance. Advanced by Assembly. Passed by Assembly 78-1. Pending in Senate.

AFFECTING MEDICAL LICENSURE

5A—Duncan. This bill, introduced for the Interim Committee on Taxation, would abolish special legal counsel for the state departments, including the State Board of Medical Examiners.

Advanced in Assembly.

68A—Hinckley. The present law provides that a physician convicted of a crime in the course of his professional conduct shall have his license revoked. This bill provides that the court "may" do so instead of "shall," and further, should the license be revoked, empowers the court to restore the license.

Killed by Assembly; reconsidered 52-31; amendment introduced; re-referred to Committee on Public Welfare.

The amendment so changes the bill that when adopted the bill will then only provide that in cases where a physician's license has been revoked for a first offense, it may be restored by the Court upon written approval of the President of the State Board of Medical Examiners.

Substitute offered by State Medical Society clarifying and adding requirements. Substitute adopted by Assembly. Bill advanced by Assembly.

168S—Morris. This bill is introduced by request of the State Board of Medical Examiners. Its provisions are:

1. Abolishes special legal counsel.
2. Provides that foreign applicants must have first citizenship papers and have foreign credentials translated by Board. Raises license fee for foreigners from $25 to $50.
3. Present law pertaining to measures is scattered through three sections. This is compiled into one section.
4. Substitutes one examiner for masseurs instead of three.
5. Provides that the Board, rather than the Court, shall revoke licenses of those convicted of a crime in the course of their professional conduct.
6. Provides that applicants for license to practice medicine and surgery must have completed internship.
7. Provides that fee for reciprocity (now $50 in all cases) shall not be less than $50 and shall be equal to fee charged Wisconsin applicants in state from which reciprocity is desired.

Passed by Senate. Recommended by Assembly Public Welfare Committee. Advanced by Assembly. Passed by Assembly. Pending before Governor.

239A—Withrow. This bill is introduced by request of the State Board of Medical Examiners. It provides for an appropriation of $5,000 annually to the board for the purposes of law enforcement efforts.

Recommended for passage by Assembly Committee on Public Welfare. Advanced by Assembly 86-3. Referred to Joint Committee on Finance. Recommended for passage 13-0 Advanced by Assembly. Passed by Assembly 75-2. Pending in Senate.

416S—H. H. Smith. This is an eighteen-page bill enacting an entirely new State Narcotic Act. Proponents of the measure are federal narcotic officials. The bill would entwine the state law with the Harrison Narcotic Act (federal). The bill was full of objectionable features to physicians.

The State Medical Society proposed substitute amendment 1 S. This substitute amendment brings present State Narcotic Act to date and strikes out of the present act features objectionable to physicians.

Substitute amendment 1-S recommended for passage by Senate Committee on Education and Public Welfare. Pending in Senate.

GENERAL HEALTH MEASURES

219S—Teasdale. A bill to empower the State Board of Health to adopt and enforce rules and regulations governing the purchase, sale and distribution of shoe dyes, poisonous fireworks, cosmetics, or other poisonous or noxious products other than food or drug products. This bill carries out preventive measures suggested by the American Medical Association.

Amended to drop word "cosmetics." Passed by Senate. Pending in Assembly.

182S—Hunt. This measure provides that lye shall be labeled as poison and two antidotes listed on the label. This is a uniform state bill fostered by the American Medical Association and the State Medical Society of Wisconsin.

Passed by Senate. Pending in Assembly.

470A—Assembly Committee on Public Welfare. This bill, introduced by request of the State Board of Health, aimed to make clear the fact that a violation of present State Quarantine Law was a misdemeanor, and provided penalties.

Chiropractors introduced amendment 1A to provide that they might attend cases of contagious diseases on the same basis as physicians.

Amendment 1A adopted in Assembly, 56-25. Bill as amended advanced 45-44.

Medical Board Bill Passes Legislature; Special Law Enforcement Measure Passes Assembly

The omnibus bill to bring the Medical Practice Act of 1915 to date received final legislative approval during April. The bill now requires but the signature of Governor Fred Zimmerman to become a law. Final approval was also given Dr. McDowell's bill to revise to date the State Medical Society of 1841.

Important revisions included in the medical practice bill included an internship as a prerequisite to taking the Wisconsin examination; first citizenship papers required of foreigners; abolishes special counsel for the board; substitutes one examiner for masseurs instead of three, and clarifies reciprocity provisions.

The third week in April saw final assembly approval given to Bill 239-A, Mr. Withrow, which would appropriate to the Board of Medical Examiners $5,000 a year for the two years beginning July 1st, next. This money would be used to drive quacks from the state. The bill now goes to the senate where it will be acted upon during May.

Federal narcotic officials in Wisconsin presented the medical profession with an April surprise by advocating an entirely new state narcotic law. The bill, eighteen pages in length, repealed the old law and substituted a law based upon the Harrison Narcotic Act but, in general, more stringent than the federal regulations. The bill was strenuously objected to by the State Medical Society and as result of special conferences, a substitute amendment was presented to the committee which makes only necessary changes in the present state narcotic act. The substitute amendment also strikes from the present law those sections placing undue restrictions upon physicians in their practice, and would permit the sale of hypodermic syringes upon order of a physician. The substitute amendment received approval of the senate committee on education and public welfare and will undoubtedly be adopted by the senate. Such action will automatically kill the original bill.

Hon. Frederick J. Petersen, R.M.
Milwaukee
Member of Assembly.

"The Basic Science Law may be but little recognized by the public now but I declare that it is the best measure for the public that this legislature has passed in the last twenty-five years. Its value to the public will be increasingly recognized as years pass on and the time will come when its true worth and value will be known throughout the state."—From a speech in the Assembly, 1927.

The model state bill requiring that lye and like caustic solutions be labeled as poison (endorsed by the American Medical Association) was passed by the senate. This bill is now pending in the assembly and will probably receive the approval of that body.

CHIROPRACTIC VERSUS BOARD OF HEALTH

Chiropractors won a victory in the lower house of the legislature Thursday, April 21, when Bill 470-A was advanced allowing them entrance to quarantined premises.

Assemblyman William C. Coleman, Milwaukee socialist, author of the chiropractic amendment adopted, sponsored it upon the floor, declaring his objection to lobbying methods against it.

The people's right of choice in the matter of a doctor or healer was argued by Assemblyman Henry A. Staab, Milwaukee, chairman of the committee on public welfare, which recommended the change advantageous to chiropractors.

The amendment to the bill concerning quarantine violations, giving "licensed practitioners" equal rights with physicians, nurses and clergymen to enter quarantined premises was accepted by a vote of 56 to 25 and the bill as amended advanced 45 to 44.

Dr. A. J. McDowell, Soldiers Grove, opposed the amendment, as an "about-face" procedure on the basic science law passed two years ago, which law he agreed, with Frederick J. Petersen, Milwaukee, is one of the most constructive acts of that session. Dr. McDowell is the only physician in the assembly. Mr. Petersen is a physio-therapist.

"The state is placed in jeopardy by allowing anyone but regular physicians to treat contagious diseases," Mr. Petersen declared.

Mr. Coleman cited his own experience with a chiropractor after diagnosis by physicians who declared he had one lung gone and another endangered by pulmonary tuberculosis. Assemblyman D. J. Vincent, Genoa City, also advocated the bill as amended, declaring that opposition to it was but one of a series to cripple the activities of chiropractors.

The State Board of Health, authors of the unamended bill, are understood as being against the bill in its present amended form and will probably oppose it when it comes up for passage in the Assembly.

Basic Science Examination

PHYSIOLOGY

BASIC SCIENCE BOARD EXAMINATION

March 19, 1927

1. Show by a drawing, giving time relations, the curve obtained by recording on a revolving drum a simple muscle twitch from a frog's gastrocnemius. What is the "latent period," and what happens during this interval? What is muscle tonus? What is meant by the optimum load of a muscle?
2. Discuss the oxygen saturation of arterial and venous blood.
3. How is arterial blood pressure measured? What factors are involved in its maintenance? What is the significance of venous blood pressure?
4. What are the actions of the hormones obtained from the thyroid, the pancreas, the posterior lobe of the pituitary, and the medullary portion of the adrenal? Which of these have been obtained in chemically pure form?
5. List the functions of the liver; of the medulla oblongata.
6. In what century and in what country did the following men live, and what did each contribute to physiology?

   William Harvey
   Claude Bernard
   Carl Ludvig
   William Beaumont

PATHOLOGY

BASIC SCIENCE BOARD EXAMINATION

March, 1927

(Answer five questions. Number correctly)

1. Give the etiology, and gross and microscopical pathology of acute purulent meningitis.
2. What interpretation attaches to the occurrence of a high leucocytosis, with an increase of polymorphonuclear leucocytes in the peripheral blood? How would you differentiate this from the blood picture in a myelocytic leukemia?
3. Discuss the events that may occur in a lung following the rupture of a tuberculous abscess within its structure.
4. Discuss the factors underlying the production of a fibrous myocarditis. What effect does such a lesion have upon the remaining cardiac muscle?
5. Name two bacteria that are common causative agents of osteomyelitis. Give the gross and microscopical findings in such a lesion.
6. Name the different types of benign and malignant tumors that may occur in the mammary gland. Describe fully the gross and microscopical appearance of any one of the tumors named.
7. Differentiate grossly and microscopically between a typhoid and a tuberculous ulcer of the ileum.

DIAGNOSIS

BASIC SCIENCE BOARD EXAMINATION

March 19, 1927

(Answer any five questions—and only five. Number correctly.)

1. What are the diagnostic signs and symptoms of rickets in childhood?
2. Give the differential points in diagnosis of empetigo contagosum and ring worm of the skin.
3. What constitutes a routine urine examination and of what diagnostic significance are at least three possible findings?

4. Of what diagnostic significance is edema of the extremities? Name conditions in which it may be encountered.
5. What are the main diagnostic signs and symptoms of acute peritonitis?
6. What are the *main* diagnostic signs and symptoms which should be looked for in first and second stage syphilis? Name the possible *terminal* phases of this disease (do not describe).
7. List the so-called contagious children's diseases and state the diagnostic points of *one*.

HUMAN ANATOMY

BASIC SCIENCE BOARD EXAMINATION

March, 1927

(Answer six questions.)

1. (20 points)
Give the chief muscles concerned in the production of the following movements:
   a. Protrusion of the mandible.
   b. Supination of the fore-arm.
   c. Adduction of arm.
   d. Flexion of thigh.
   e. Abduction of thigh.
2. (20 points)
Describe an artery, vein, and capillary, pointing out how their various anatomical features are related to their function.
3. (20 points)
Locate and give the fundamental nature of the following:
   a. Vagus nerve.
   b. Superior cervical sympathetic ganglion.
   c. Submaxillary ganglion.
   d. Third thoracic spinal ganglion.
   e. Fiber tracts in general.
4. (20 points)
Give a general discussion of glands including their fundamental structure, varieties, location, etc.
5. (10 points)
Describe the fundamental structure of a typical freely movable joint.
6. (10 points)
What is the body cavity or coelom and what are its subdivisions?

RADIOLOGICAL SECTION MEETS

The Radiological Section of the State Medical Society of Wisconsin will hold its semi-annual meeting at La Crosse on Saturday, May 14th.

Dr. James A. Evans is chairman of the program committee and announces the preliminary program to include the following papers:

Registration at Stoddard Hotel.

Morning Session:

Demonstration of films at Lutheran Hospital and St. Francis Hospital.

Phrenotomy for Multiple Stones in Pelvis of Kidney with Demonstration of Technique with Portable X-Ray Apparatus to Determine Thoroughness of Removal of Stones—Dr. E. Evans, Dr. McGarty, Dr. J. Evans, La Crosse.

Afternoon Session:

Business Session.

Irritable Colon—Dr. McLoone, La Crosse.

Subject to be announced later — Dr. Sisk, Madison.

Demonstration of Genito-Urinary Films—Dr. E. Evans, Dr. Bannen, La Crosse.

Subject to be announced later — Dr. Potter, Marshfield.

Subject to be announced later — Dr. Baird, Eau Claire.

Dinner at Country Club.

Evening Session:

Address by Dr. Gentz Perry, Chairman of State Section on Radiology.

STATE HOSPITAL CONVENTION

The annual meeting of the Wisconsin Hospital Association is announced for the Pfister Hotel, Milwaukee, on Monday and Tuesday, May 23rd and 24th. Registration opens at 9:00 Monday morning followed by reports of officers.

Subjects to be discussed during Monday include: Physical Therapy in a Hospital by Dr. J. C. Elsom, Madison; Hospital Administration by Dr. J. W. Coon, Stevens Point, and Mr. Charles F. Karrow, Milwaukee, and a round table on hospital problems. During the afternoon there will be visits at various hospitals in Milwaukee and the evening will be devoted to a discussion of nursing and social service problems.

Subjects on the Tuesday program include: Collection of Hospital Bills, Cost of Hospital Service, a round table on hospital problems, and a banquet at Hotel Pfister on Tuesday evening. Speakers at the banquet will be: Hon. Judge A. C. Backus, Milwaukee; Dr. Wm. H. Walsh, Secy., American Hospital Assn., Chicago; Rev. C. B. Moulinier, Pres., Catholic Hospital Assn., Milwaukee, and Miss Laura R. Logan, Dean, Illinois Training School for Nurses, Chicago.

THE JOURNAL BOOK SHELF

Principles and Practice of Chemotherapy, with special reference to the specific and general treatment of syphilis. By John A. Kolmer, M. D., Professor of Pathology and Bacteriology in the Graduate School of Medicine, University of Pennsylvania. Pages, 1,106, with 82 illustrations. Price, cloth, $12.00, net. W. B. Saunders Company, Philadelphia and London.

A Manual of Pharmacology and Its Application to Therapeutics and Toxicology. By Torald Sollmann, M. D., Professor of Pharmacology and Materia Medica in the School of Medicine of Western Reserve University, Cleveland. Third edition, entirely reset. W. B. Saunders Company, Philadelphia and London.

Report of the Department of Health of the City of Chicago for the Years 1923, 1924, and 1925. By Herman N. Bundesen, M. D., Commissioner of Health, Chicago, 1926.

South America. A guide book for lay and professional travelers. By Franklin H. Martin, M. D., in collaboration with William J. Mayo, M. D., Francis P. Corrigan, M. D., and Edward I. Salisbury, M. D. Price, $3.00. Fleming H. Revell Co., 158 Fifth Ave., New York City.

An Introduction to the Practice of Preventive Medicine. By J. G. Fitzgerald, M. D., Professor of Hygiene and Preventive Medicine and Director, School of Hygiene and Connaught Laboratories, University of Toronto; assisted by Peter Gillespie, Professor of Civil Engineering, University of Toronto, and H. M. Lancaster, Chief Dominion Analyst, Department of Health, Canada. Second edition. Price, $7.50. C. V. Mosby Company, St. Louis, 1926.

History Taking and Recording. By James A. Corscaden, M. D., Associate in Obstetrics and Gynecology, Columbia University, New York. Price, $1.50. Paul B. Hoeber, Inc., New York, 1926.

Hospital Housekeeping and Sanitation. By Nora P. Hurst, R.N. Price $1.25. C. V. Mosby Company, St. Louis, 1926.

A Manual in Preliminary Dietetics. By Maude A. Perry, B.Sc., Director of Dietetics, The Montreal General Hospital, Montreal. Price, $1.25. C. V. Mosby Company, St. Louis, 1926.

A Primer for Diabetic Patients. By Russell M. Wilder, M.D., Section on Nutrition, Division of Medicine, Mayo Clinic. A brief outline of the treatment of diabetes with diet and insulin, including directions and charts for the use of physicians in planning diet prescriptions. Third edition, reset, 134 pages. Price, $1.50 net. W. B. Saunders Company, Philadelphia and London, 1927.

Human Pathology. A Textbook by Howard T. Karsner, M.D., Prof. of Pathology, School of Medicine, Western Reserve University, Cleveland, Ohio. With an introduction by Simon Flexner, M.D. Illustrations, 20 and 443, black and white. J. B. Lippincott Company, Philadelphia and London.

Modern Practice of Pediatrics. By William Palmer Lucas, M.D., Prof. of Pediatrics, University of California Medical School. Price, $8.50. The Macmillan Company, New York.

Medical Clinics of North America. Vol. X, No. 4, New York Number. W. B. Saunders Company, Philadelphia and London, 1927.

Four Thousand Years of Pharmacy. An outline history of pharmacy and the allied sciences. By Charles H. LaWall, Ph.M., Prof. of Theory and Practice of Pharmacy and Dean of the Philadelphia College of Pharmacy and Science. Illustrated. J. B. Lippincott Co., Philadelphia and London.

Medical Clinics of North America. Volume IX, Number V, Chicago number, March, 1926. Octavo of 206 pages with 34 illustrations. Per clinic year, July, 1925, to May, 1926: Paper, $12.00; cloth, $16.00, net. W. B. Saunders Company, Philadelphia and London.

Medical Clinics of North America. Volume IX, Number VI, Chicago number, May, 1926. Octavo of 202 pages including complete index to Volume IX, with 24 illustrations. Per clinic year, July, 1925, to May, 1926: Paper, $12.00; cloth, $16.00, net. W. B. Saunders Company, Philadelphia and London.

The Conquest of Disease. By Thurman B. Rice, M.D., Assistant Professor of Sanitary Science, Indiana University School of Medicine, and former State Health Commissioner of Indiana (The Macmillan Co., New York), is one of the first of the 1927 contributions to the literature of disease control. The author announces three purposes: (1) To set forth the more recent scientific information, (2) to make it interesting, (3) to emphasize the advances that have been made and to create confidence in the science of disease prevention.

BOOKS RECEIVED FOR REVIEW

The Fifth Avenue Hospital Clinics. First series, based on the material from the semi-monthly staff meetings. Illustrated. Price $5.00. Paul B. Hoeber, Inc., New York City, 1927.

Obstetrics for Nurses. By Joseph B. DeLee, M.D., Prof. of Obstetrics, Northwestern University Medical School, Chicago. Eighth edition, revised. Pages 635, with 266 illustrations. Cloth, $3.00 net. W. B. Saunders Company, Philadelphia and London, 1927.

Nineteenth Annual Conference of the American Association of Medical Milk Commissions and The Certified Milk Producers' Association of America, May 25-26, 1925, Chalfonte-Haddon Hall, Atlantic City, N. J.

Methods and Problems of Medical Education. Sixth series. Division of Medical Education, The Rockefeller Foundation, 61 Broadway, New York City, 1927.

Tiger Trails in Southern Asia. By Richard L. Sutton, M.D., Fellow of the Royal Geographical Society and Prof. of Dermatology, University of Kansas. With 115 original illustrations. Price, $2.25. C. V. Mosby Company, St. Louis, 1926.

Diseases of the Skin. A practical treatise for the use of students and practitioners. By Oliver S. Ormsby, M.D., Clinical Professor and Chairman of the Department of Dermatology, Rush Medical College of the University of Chicago. Third edition, thoroughly revised. Illustrated with 521 engravings and 3 colored plates. Price $11.00. Lea & Febiger, Philadelphia, 1927.

DO NOT OVERLOOK THE FEET IN YOUR EXAMINATION

The symptoms of corns, callouses, bunions, burning, aches, pains, hammer toes, flat feet, and Morton's toe point to the falling of one or more of the arches of the feet. The x-ray picture above shows the cuboid bone dropped down along its inner border; and since this bone is the outer edge of the Posterior Transverse Arch, it proves that this, the main arch of the foot, has fallen.
Back of the falling of the three transverse arches and the two longitudinal arches we have a twisting of the os calsis with its lower border to the outside. This is proved by the bulging counter and run over heel—on the outside. Examine the shoes for these telltale marks.

Feet Cause Serious Trouble

Ptoses, pelvic pathology, backaches, insomnia, indigestion, etc., can all be caused by the feet being out of balance. The feet out of balance disturbs the balance of the entire body—spine, organs, etc., and serious conditions are the result.

Remove the Cause

Our ultra-simple appliance — the NATURE-TREAD — with the wedge at the heel to restore the os calsis into its proper place and the metatarsal elevation to remove the strain from the fallen transverse arches will establish the perfect balance and Nature does the rest.
Write for our booklet, "Foot Ailments" and How Nature-Treads remove the cause.

Nature-Tread Co. of Illinois
655 S. Wells Street
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Bowland Shoe Co., Baraboo
Fitzsimmons & Sons Co., Fond du Lac
Ascher Bercu, New Bargain Store, Fox Lake
Olson & Son, Frederic
Homer Maes, Green Bay
Barden Store Co., Shoe Dept., Kenosha
Cohn's Shoe Store, Kenosha
Rice & Thompson, 117 N. Fourth St., La Crosse.
Schumacher Shoe Co., Madison
Walk-Over Boot Shop, Madison
Sol Friedstein & Sons Co., Marinette
Mr. H. J. Tuchscherer, Menasha.
Kundert's Shoe Shop, Monroe
Nelson Shoe Store, Racine
Kahn Dry Goods Store, Racine
S. B. Gary, Rhinelander
Luck's Shoe Store, Rhinelander
Eugene Meyer, Watertown
Leo Ruesch & Son, Watertown
Porath & Schlaefer, 514 Third St., Wausau

"What's in a Name?"

evidently means more to many investors than it should. Prejudices and fallacies such as "I never buy stock," "Is it a gold bond?" are based upon a name rather than upon the equities and intrinsic values behind the security.

There are Preferred Stocks of large, established, successful companies that we would rather recommend than many a bond of smaller, newer and perhaps more struggling concerns.

Such a one, paying 6½% annually in quarterly dividend checks is the Cumulative Preferred Stock, Series "B" of the Wisconsin Public Service Corporation. Because of the continually increasing need for its service in the Fox River Valley its earnings are now **three times the dividends on this Preferred Stock.**

While available you may purchase for cash, or on our Partial Payment Plan with only a 10% initial payment.

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Please enter my order for ..... shares Wisconsin Public Service Corporation 6½% Preferred Stock at $100 per share.

Payment to be made upon receipt of statement ☐, Partial Payment Plan ☐, Check for $..... enclosed ☐.

Name .....

Address .....

New circular giving earnings as of February 28, 1927, is yours for the asking.

Principles of Chemistry. An introductory textbook of inorganic, organic and physiological chemistry for nurses and students of home economics and applied chemistry, with laboratory experiments. By Joseph H. Roe, Ph.D., Prof. of Chemistry, George Washington University Medical School, Washington, D. C. Illustrated. Price $2.50. C. V. Mosby Company, St. Louis, 1927.

Diseases of the Digestive Organs. With special reference to their diagnosis and treatment. By Charles D. Aaron, M.D., Prof. of Gastro-Enterology and Dietetics in the Detroit College of Medicine and Surgery. Fourth edition thoroughly revised. Illustrated with 174 engravings, 70 roentgenograms and 13 colored plates. Price $11.00. Lea & Febiger, Philadelphia, 1927.

Management of the Sick Infant. By Langley Porter, M.D., Prof. of Clinical Pediatrics, University of California Medical School, and William E. Carter, M.D., Instructor in Pediatrics, University of California Medical School, San Francisco. Third revised edition. Illustrated. Price $8.50. C. V. Mosby Company, St. Louis, 1927.

Examination of Children. By clinical and laboratory methods. By Abraham Levinson, M.D., Associate in Pediatrics, Northwestern University Medical School. Second edition, with 85 illustrations. Price $3.50. C. V. Mosby Company, St. Louis, 1927.

A Manual of Gynecology. By John Osborn Polak, M.D., Prof. of Obstetrics and Gynecology, Long Island College Hospital; Prof. of Obstetrics in the Dartmouth Medical School. Third edition, thoroughly revised. Illustrated with 145 engravings and 12 colored plates. Price $5.00. Lea & Febiger, Philadelphia, 1927.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 153 Oneida Street, Milwaukee, Wisconsin. These new books will be loaned for an inspection period only.

Physiotherapy. Theory and clinical application. By Harry Eaton Stewart, M.D., President-elect American Academy of Physiotherapy, director New Haven School of Physiotherapy. Paul B. Hoeber, New York.

This book is by an author that has contributed more good literature to physiotherapy than anyone else writing on the subject and this book is by far his best effort. His attitude primarily on physiotherapy is that the disbeliever has a great deal to learn and that the fanatic on the subject must moderate his views considerably. The book is written both for the beginner and the experienced physiotherapist. The physics of the different modalities are gone into thoroughly particularly galvanism, faradism, static and high frequency currents. Other forms of physical therapeutics discussed are phototherapy, thermotherapy, massage, exercise, actiniotherapy and hydrotherapy. Why actiniotherapy should not be considered with phototherapy and thermotherapy with high frequency and hydrotherapy we do not quite understand. The book, however, is written more particularly for electro and photo therapy and the other forms of physical therapy are more or less neglected in that part of the book dealing with clinical application. Like most men dealing with this subject he is inclined to find a place for this therapy in all surgical and most medical diseases. There is also the tendency to blame the lack of good results in others to faulty technic. The book as a whole is instructive and should be in the hands of anyone doing physiotherapy. It rather lacks the tone of conservatism that is so essential in bringing about the general approval and adoption of physiotherapy by the medical profession. It is pleasing to note in reading this book that there was no suggestion of an affiliation with manufacturers of apparatus as has generally been the case in similar publications. We would like to have seen some recommendation as to how the practice of physiotherapy might be kept in trained and intelligent hands. Certainly the whole procedure is not as simple as the author would have us believe.—*M. Q. H.*

Electrothermic Methods in Neoplastic Diseases. (Desiccation and Coagulation) Designed as a practical handbook of surgical electrotherapy for the use of practitioners and students. By J. Douglas Morgan, M.D. Illustrated with 36 engravings. Price, $2.50. F. A. Davis Company, Philadelphia, 1926.

For a book of 160 pages a great deal of space is devoted to the history and elements of electrotherapeutics. Then the subject of electrodesiccation and electrocoagulation are approached rather abruptly from the elementary physics of electricity. These procedures we take it are to be undertaken only by the most astute physiotherapists. It is assumed that the operator is essentially a surgeon as nothing is said of surgical training. Fortunately surgical asepsis requires but little attention as the field of operation is rendered aseptic by the application of the high frequency current, unfortunately but little is said of the danger of secondary hemorrhage, thrombi and emboli. As far as can be gathered from the text surgical diathermy has no virtues that can offset the above mentioned possible complications. The book is chiefly a résumé of the literature on the subject and presented very enthusiastically. The illustrations consist mainly of apparatus, the author has played no favorites as most of the manufacturers are represented. The different technics described should be attempted only by those who are experienced surgeons as well as being intimately acquainted with the use of the high frequency current. Unfortunately the apparatus as well as the book is accessible to any of the cultists and the apparent simplicity of the technic can easily result disastrously.—*M. Q. H.*

Health Supervision and Medical Inspection of Schools. By Thomas D. Wood, M.D., college physician, adviser in health education, and professor of physical education, Teachers College, Columbia University, and Hugh G. Rowell, M.D., physician to the Horace Mann School, lecturer and assistant physician, Teachers College, Columbia University. Octavo of 637 pages, with

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65 E. LAKE ST. CHICAGO, ILL.

243 illustrations. Cloth, $7.50 net. W. B. Saunders Company, Philadelphia and London, 1927.

This is the most complete and satisfactory exposition of the subject that has come to the attention of this reviewer. It is not a book for consecutive reading. It is rather an encyclopedia for reference. In spite of the fact that it is 600 pages, it is conspicuous for the conciseness, brevity and clearness of its exposition.

Each division of the subject is handled from the standpoint of aims, ideals, present practice, successful methods and methods which are classified, because of past failures, as undesirable. The handling of unsettled and controversial questions is particularly satisfactory, being in most instances a presentation of both sides of the question followed by a brief statement of the opinions of the authors.

It was written for educators and official and voluntary public health workers, and no member of these groups should be without access to it. The practicing physician could not fail to broaden his conception of public health work, especially school hygiene, by reading it.

It is an eminently practical presentation of the subject, replete with specific plans and methods and profusely illustrated with pictures, diagrams and printed forms. These latter should be particularly valuable to the educator or health executive confronted with the problem of devising organization and record systems for school hygiene projects.

Contagious disease control, physical examinations, school lunches, gymnastics and athletics, the health of the teacher, the janitor's place in the health program, posture and the appliances for improving it are all considered with the point of view which denotes wide experience with the practical as well as the theoretical aspects of school hygiene in its broadest sense. Even the child in industry finds a place, and this subject is discussed with a noteworthy absence of bias toward either the extremely progressive or the extremely conservative attitudes.

Throughout the book while the authors hold forth the highest of ideals they recognize the necessity of facing the facts in a situation and adapting the school health program accordingly.—*W. W. B.*

Pseudo-Appendicitis. A study of mechanical syndromes of the right lower quadrant simulating appendicitis by Thierry de Martel, surgeon to the Paris Hospital, and Edouard Antoine, attending physician to the Paris Hospital. Translated from the French by Dr. James A. Evans, formerly assistant radiologist, St. Antoine Hospital, Paris, France. Published in 1925 by the F. A. Davis Company in cloth binding, 201 pages with 41 engravings.

In this small volume the authors set out to classifiy, describe, differentiate in diagnosis, and describe the proper treatment for the many pathological lesions causing pain in the right lower quadrant of the abdomen which so frequently are mistaken for appendicitis. Many of these conditions described are inflammatory, others are anatomical anomalies, either natural or acquired. That the correct differentiation of appendicitis from all other painful right lower quadrant syndromes is a very important subject no one will dispute. The description of the lesions simulating appendicitis is splendid, the differential diagnosis at times becomes a bit hazy, while the treatment leaves considerable to be desired. It should be a very valuable addition, however, to every surgeon's library.—*E. S. S.*

The Diseases of Infants and Children. By J. P. Crozer Griffith, M.D., Prof. of Pediatrics in the Graduate School of Medicine of the University of Pennsylvania, and A. Graeme Mitchell, M.D., Prof. of Pediatrics, College of Medicine, University of Cincinnati. Second edition, reset. Two octavo volumes totaling 1715 pages with 461 illustrations, including 20 plates in colors. Cloth, $20.00 net. W. B. Saunders Company, Philadelphia and London.

This work is an exposition of the thought and methods of the Philadelphia school of pediatrics. It is written in a conservative style, but due attention is given to the latest advances in this specialty. A text of this type stands midway between the one volume works and the large encyclopedic texts, such as Abt or Pfaundler and Schlossman. There is an enormous amount of material in these two volumes and the various subjects are fully considered. The sections on contagious diseases and nervous and mental diseases in infancy and childhood are especially fine. The section on artificial feeding is not as clear as one would like to have it and the method of top milk feeding is not used to any great extent in most parts of the country. The equations given for calculating the percentages of milk and other ingredients belong to an age which has been superseded by simple methods. A further criticism might be made of the prescribing of much medicine for every ailment. The present tendency in pediatrics is the use of few drugs and much hygiene. In spite of these criticisms, the work remains a very valuable contribution to pediatric literature and a worth-while textbook for any physician—*R. M. G.*

The Fifth Avenue Hospital Clinics. First series, based on the material from the semi-monthly staff meetings. Illustrated. Paul by Hoeber, Inc., Publishers, New York City, MCMXXVII. Price, $5.00.

This volume of activities of the staff of the Fifth Avenue Hospital, New York, is the result of a desire on the part of the Staff to collect their papers into one volume and to reveal to the medical world what they are doing.

Following a few pages devoted to the roster of the staff and the various departments, there is a short eulogy of their most interested and enthusiastic supporter, Mr. T. Frank Manville, whose untimely death must have been a great loss to the hospital.

The remainder of the book is made up of a collection of clinical reports from all departments, some very brief, others longer. There are many interesting case reports. Occasionally a whole meeting of the staff is reported with discussion.

I note some serious typographical errors such as "emphysema" several times for "empyema" on page 88. Spelling of proper names might have been more carefully edited. The Professor of Physiology at Toronto is McLeod not McCloud.

The Wisconsin Medical Journal

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Non-Specific Protein Therapy; Its Action and Its Application*

By ERNST F. MUELLER, M. D.,
Hamburg, Germany.

I appreciate very much your invitation to present to you a review of the results of the mutual studies of Dr. Petersen and myself, carried out over a number of years at the University of Illinois and at the University of Hamburg.

Almost every field of medicine has some relationship to non-specific protein therapy, the underlying principles of which are much older than its conscious introduction into medical therapy.

The more we learn about the action and the effect of non-specific protein agents, the more we realize that centuries ago similar and even like principles were applied in the treatment of the sick. Even under most primitive conditions, mainly when combating infectious diseases, these agents were applied empirically in the remote and in the recent past.

Non-specific protein therapy in its modern form was introduced about fifteen years ago by Viennese physicians after the very minute work of Weichard, Schmidt and others. It is now being used in various forms in almost every country. Experience has shown that the administration of foreign agents has been of help in reinforcing resistance against infections. In America bacterial emulsions, such as typhoid vaccines have thus been used while in Europe, since the introduction of milk by Schmidt, milk and its derivatives, caseine and other like products have taken their place because they produce a similar reaction but with more comfort to the patient.

The studies upon the action of non-specific therapy took two principal and differing directions. One group of physicians has devoted all efforts to solving the manner in which non-specific agents act generally and how they influence single organs and organic systems. Another group, scientists, as well as practitioners, has tried to ascertain and to limit the field in which non-specific protein therapy should be used empirically. Much as we esteem the value of these latter developments, we believe that fixing the modus operandi of non-specific protein therapy constitutes the safer way to determine when it should be applied. This latter procedure accorded us the main channel of our studies, and I shall try to review briefly the results Dr. Petersen and I obtained.

If non-specific protein agents, whatever they may be, are injected into the body, a reaction occurs which involves almost every organ of the economy. Under non-specific protein agents we include all agents from the toxic vaccine to those which do not cause visible clinical symptoms in healthy people, but produce well determinable functional changes. The general reaction has been analyzed by determining the individual reactions of single organs. The reaction of an organ usually consists of a functional change not necessarily accompanied by demonstrable histologic alteration. Functional changes under usual circumstances represent merely an increase or a decrease in the specific action of the particular organ, and both increase or decrease may be clinically as well as experimentally demonstrable by certain measureable symptoms.

In this general reaction certain types of functional changes of all body organs have been observed. The character of the functional changes leads to a distinct division into two groups of organs according to their reaction toward non-specific agents. One group always reacts first with an increased action, while the other group simultaneously reacts with a decrease of its functional activities. Under normal circumstances all organic functions are in a certain equilibrium—a state of moderate activity tonus—which is easily adapted to the natural physiologic requirements; but whenever the activities are increased or decreased to a recognizable extent, the organs of the splanchnic area (abdominal organs) react oppositely to those extra-abdominally located and vice versa.

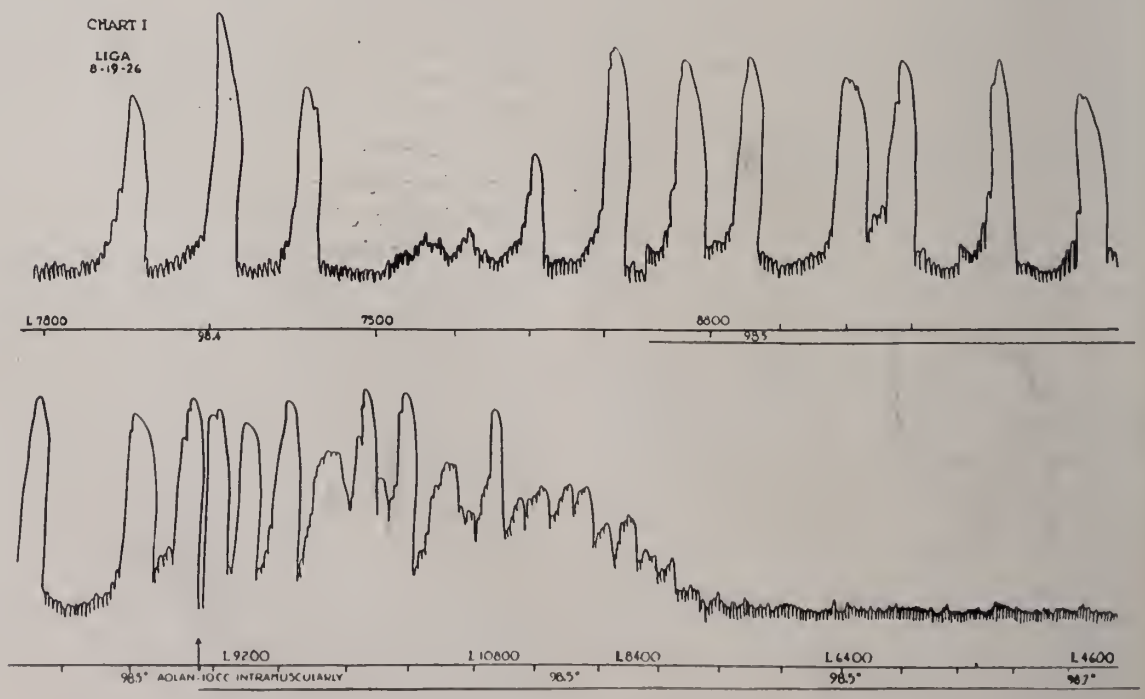
* Presented before the State Medical Society of Wisconsin, Madison, September, 1926.

In every protein reaction the organs of the splanchnic region (liver, stomach, etc.) increase their action more or less intensively, while a decrease of organic activity will be noticeable in the peripheral organs, the intensity of which always corresponds to the increase of activity in the splanchnic area. One example will explain this oppositely oriented response of the two groups. We know that after the intake of food into the stomach, the stomach dilates, the stomach tissues become more permeable, stomach secretion increases. Liver tissues show a similar reaction, bile and lymph are produced on a higher scale and the entire vascular system of the splanchnic area is dilated and filled with blood. The organs of the periphery show the opposite response. Slight contractions of the vascular system will be found all over the skin, the muscles, etc. Later peristalsis starts, contraction of muscles and vascular system is demonstrable in the splanchnic region and an opposite orientation of the peripheral organs takes place.

Such waves of alternating organ action, under normal conditions, continue throughout life. If any foreign protein finds entrance into the body, no matter whether by injection or through bacterial infection, the body resistance toward this invasion of foreign material asserts itself with a more or less sudden increase in the organic activities of the splanchnic region, while an opposite orientation takes place in the peripheral organs. Thus we have an immediate reaction of the same groups which in principle is not different from what happens, for instance, after the intake of food, but the intensity of which is measurably increased according to the increased toxicity of the protein injection or of the bacterial invasion.

CLINICAL VALUE

It would lead too for to give details concerning this synergistic action of all the organs, but it should be emphasized that this relationship between the two groups of organs is not merely of theoretic interest, but is of great value for the understanding of clinic phenomena. You know the phenomenon of a chill which appears as well after the invasion of bacteria into the vascular system as after the injection of typhoid vaccines for instance. You know that the skin (one part of the peripheral organs) réacts with a sudden contraction; our recent studies show that the liver, during the same time reacts with highly increased activity, increased permeability and increased production of bile and lymph. If we agree that the simultaneous vascular reaction (contraction of the skin vessels, dilatation of the liver vessels) depends upon the cooperative action of the vasomotor nerve, we also want to emphasize that the inseparably connected functional changes are like-



wise dependent upon this synergistic reaction of the vegetative nervous system.

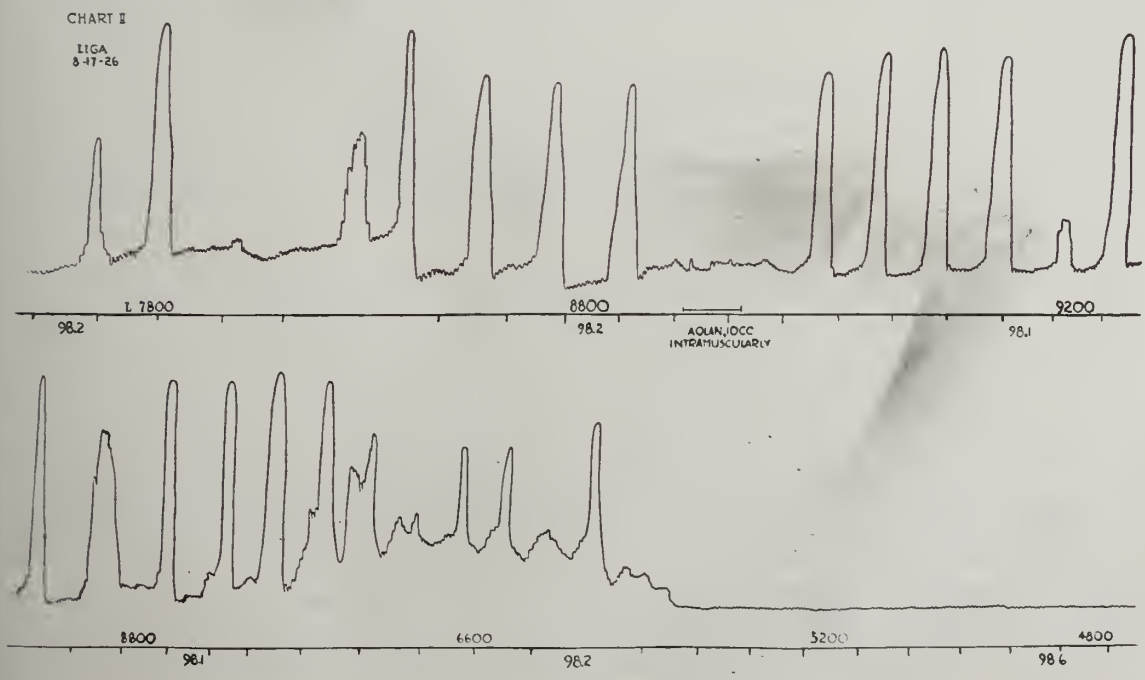
A chill is perhaps the best example to explain non-specific protein reaction clinically. We know that a chill represents a general reaction with a functional alteration of the autonomic apparatus (the splanchno-peripheral balance). The alteration of skin and liver function has been mentioned before. We have studied one other phenomenon very commonly accompanying a chill. Many diseases, such as pneumonia, starting with a chill, as the result of a primary invasion of bacteria, are accompanied by sudden vomiting. This vomiting in chills is the result of a sudden dilatation of the stomach coupled with a suddenly increased production of stomach secretion. The vomiting occurs without stomach contractions and as the result of relaxation of the cardia, so that the abdominal pressure upon the dilated stomach empties the suddenly secreted juice through the open cardiac orifice. The same relaxation often concerns the pylorus and a regurgitation of bile takes place without the slightest retroperistalsis.

From this, as from other observations we conclude that protein action involves a reaction of the entire vegetative nervous system, which manifests itself in sudden functional changes of organic activities. These are directed in two different channels, namely, (1) a dilatation and an increase of action in the entire splanchnic area combined with (2) a contraction of the peripheral vessels, and a decrease in skin activities and in the functioning of other peripheral organs. We do not always have a picture as intensive as a chill, but we have seen the same type of reaction after the employment of any and every foreign substance used in protein therapy. It clearly shows that at least one system, namely, the involuntary nervous system, reacts immediately to every injection of a foreign protein.

Summarizing the action of non-specific protein therapy, we wish to emphasize that every injection of a foreign protein leads to a reaction very similar to that which any infection would produce in a normal human being. In infections like septicemia after abortion, or pneumonia, just as after the therapeutic injection of a foreign protein, we always have to deal with the same phenomenon manifesting itself as an increase of all functional activities in the splanchnic region, and the opposite condition of the peripheral organs. It very probably represents a cooperative reaction of the body in order to resist, in the best possible way, the invasion of foreign material.

APPLICATION OF NON-SPECIFIC PROTEINS

Non-specific proteins should be used according to their reaction in the body. Wherever an increased resistance might be of use, non-specific proteins will be of great value. Infections certainly are the main field of protein therapy, and it will be easily understood why particularly an increase



of liver activity will help to eliminate toxic agents absorbed from local infectious diseases. But since we know that proteins are instrumental in effecting a dilatation of the vascular system, as well as functional stimulation of all the splanchnic organs, the same therapy possibly could be used to act as a therapeutic agent wherever we have to deal with contractions or spasms in the splanchnic area.

In the last few months, we have completed a series of studies which deal with this subject. The following tests have been made: we inserted a rubber balloon, first into the stomach of animals, later into that of man. The balloon was swallowed, then inflated with a certain amount of air and then connected to a kymograph. Thus, we were able to record the stomach mobility and to find that the empty stomach records small uniform wave tracings, similar in size. If the animal or the person is starved over a considerable period of time, the contractions of the stomach become more intense, and we know from the exhaustive work of Carlson, of Chicago, that stomach contractions are the underlying phenomenon that cause the sensation which we call hunger. We furthermore know that in certain diseases such as stomach ulcers and other ulcers of the digestive tract, contractions are very intensive and are accompanied by a painful sensation, in the main, similar to hunger. We know that in stomach ulcers these very intensive contractions cause pain and likewise irritate the ulcer present, and through continuous irritation prevent healing.

In all tests, animals were starved over 24 hours and longer, and intensive contractions could be traced kymographically. While these contractions were present, non-specific protein agents were introduced. We started with very toxic vaccines and living B. coli, and then gradually injected very mild albumins such as aolan. Without exception, we found that after the injection of the proteins, the stomach contraction stopped and the stomach remained relaxed for considerable periods of time.

After these preliminary tests in animals, we continued the work in humans in exactly the same way. The patients swallowed the empty rubber balloon connected with a rubber tube. The balloon, according to a method developed by Dr. Arquin of Chicago, was coated with gelatin, and it was remarkable to observe how easily the patient could swallow the hardened gelatin-coated balloon, although it is very disagreeable to a patient to swallow the soft rubber balloon alone. Waiting 15 minutes until the gelatin is dissolved in the stomach, the balloon is inflated with 80 to 100 c.c. air. The same quantity should always be used on the same patient; the tracing is made kymographically. In normal human beings intradermal injection of even the mildest foreign protein (aolan 0.1 to 0.3 c.c.) results in almost immediate reaction upon the stomach in which all contractions cease. This shows that our former tests are correct, namely: every foreign protein whether it produces an intensive reaction such as a chill or a mild reaction without marked symptoms, will always cause the organs of the splanchnic region to react similarly, producing increased vascularity and relaxation of the stomach muscles. A few tracings (Figs. 1, 2 and 3) will best illustrate this phenomenon. There is no difference between the response of normal people and of patients with gastric ulcers, therefore, the tracings are selected from ulcer patients.

In case No. 1, we have the chart of a woman with a stomach ulcer. The control time was about one hour, of which only the last part is shown in the chart. Thereafter the patient received an intra-muscular injection of 10 c.c. aolan. About ten minutes after the injection the last contraction took place. After that, a period of three more hours could be traced in which the stomach was almost entirely relaxed, there being only very few and minor contractions of that organ. It might be mentioned that the patient always indicates the sensation of pain at the moment when the contraction takes place, and it can be recorded in the tracing. It is interesting to realize how the pain disappears contemporaneously with the cessation of the contractions so that even without kymographic methods available the patient's comments reveal this action of proteins upon the stomach.

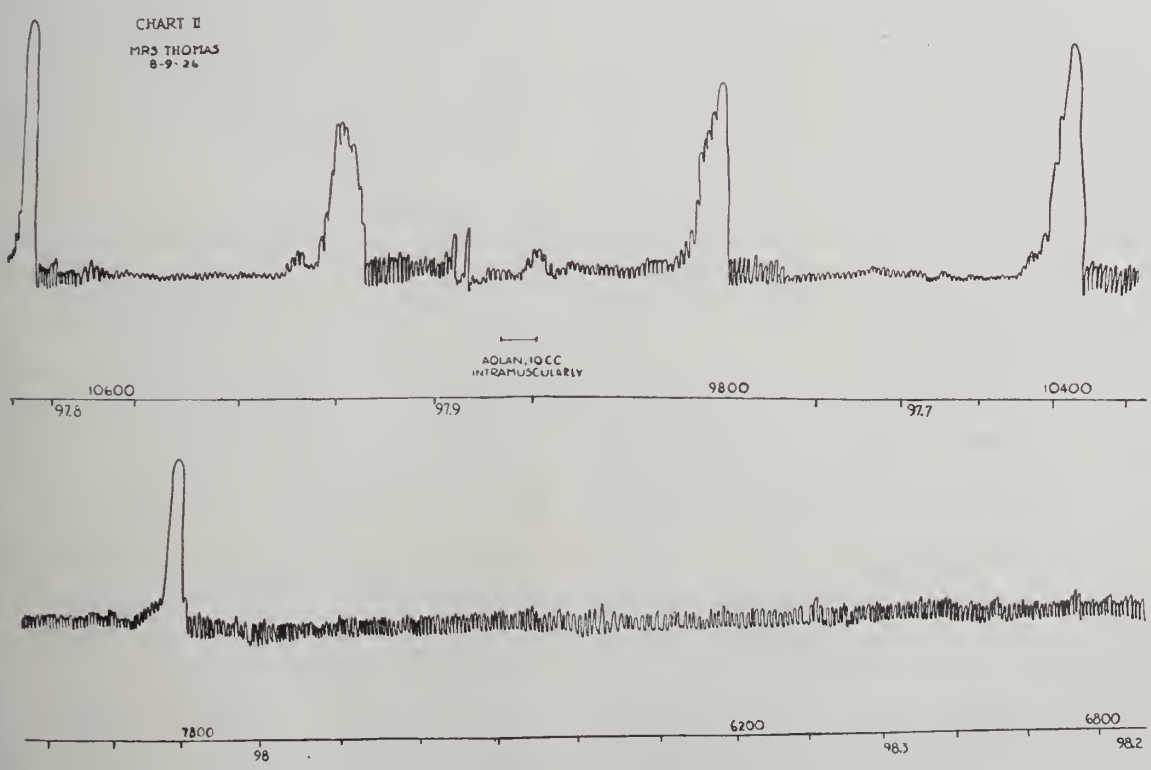
Does this method offer a cure for this particular condition? We certainly have a cure for the pain. We are of the belief from our experience in a great series of stomach ulcer patients, that protein therapy enables us to relieve the patient of the contractions for a considerable time, thus the better enabling the ulcer to heal. Our patients were treated every second day with 10 c.c. aolan, and we are of the impression that this assisted the healing process considerably. We observed that the stomach contractions became less painful and less marked from day to day, and have objective as well as subjective evidence that after

14 days these contractions almost reach the normal. Therefore, the practical application of non-specific protein therapy in stomach ulcers will be a valuable aid in relieving spasms of the organ. This can be accomplished with non-toxic proteins without any considerable discomfort, in exactly the same intensive way and lasting for hours, as with the most toxic products.

In the reported cases, the temperature rose very slightly (within normal limits) during the time the aolan action upon the stomach was demonstrable. This slight temperature increase was due to the fact that with the onset of the increased activity of the splanchnic organs, heat was produced to a larger extent than previously, while at the same time through the lessened action of the skin and the slight contraction of skin vessels, this heat could not be released to the same extent as under normal conditions. There follows a slightly higher temperature. In our cases this temperature increase has not exceeded one-half to one degree, and is therefore, merely of theoretic interest. But the tests show that full relaxation of the stomach was secured without marked increase in temperature. A method like this is concededly far superior to any other procedure which accomplishes a like result only when accompanied by high temperature and chill.

We have particularly discussed this one field of application of non-specific protein therapy because, in a way, it presents a new indication. We have emphasized the action of non-specific protein therapy as a spasmolytic measure, in order to explain and to demonstrate on a clinical subject how non-specific protein therapy acts upon the vegetative nervous system.

There are many authors who still believe that the injection of foreign proteins is more effective the more intensive the clinical reaction elicited. Others express the opinion that when a chill occurs after the injection of typhoid vaccine and a high temperature persists for a day or so, the therapeutic action is better than without the increase in temperature. This clinical example of the response of the stomach has demonstrated that we cannot have a more intensive reaction than one which completely inhibits all stomach contraction, either normal or pathologic. It also shows that even milk proteins are able to stimulate the organs of the splanchnic area and that this action is useful mainly to overcome bacteria and bacterial toxins, and in this special instance, to stop spasms.



SUMMARY

In administering protein agents we have to deal with a reaction of the body as an entity; that is the body responds in a typical way; there is a reaction of the vegetative nervous system by which all organs are changed in their functional activity. The splanchnic organs are stimulated while corresponding inhibition takes place in the periphery. This response is particularly valuable where, as in infectious diseases, increase of the detoxicating action of the liver, etc., is required. In giving protein agents we merely stimulate the same activities which are naturally stimulated after bacteria have invaded the body, as in pneumonia and other infections. In stomach ulcers, accompanied by stomach contractions, knowledge of the spasmolytic action, together with diet and the necessary general treatment proves of great value in the therapy of gastric ulcers and similar conditions, where such contractions prevail. The particular findings of protein reaction in gastric ulcers are not only of value to the practitioner so that he may know how protein therapy acts, but the knowledge of protein action upon the vegetative nervous system and its typical response may be a valuable basis for applied medical science generally.

The New Polypharmacy

By HUGH P. GREELEY, M. D.,
Madison

In connection with the publication of this paper this Journal calls attention to the fact that the standard of the Council on Pharmacy and Chemistry of the American Medical Association is the guide for our advertising as well as for all exhibits at the Annual Meeting—Editor's Note.

With the advent of the Twentieth Century, the battle against polypharmacy seemed to have been fought to a finish, but recent years have seen this medical octopus revive and insidiously grasp the profession once more in its tentacles.

This huge monster has changed his habits. It is no longer the shot gun prescription that captures the imagination and credulity of the general practitioner. It is not as Osler said, "that we are giving a large number of drugs, the action of which we know little, into the bodies, the action of which we know less." The compounded prescription containing multitudinous drugs and the proprietary of the same ilk have almost disappeared and there has been a change.

First to the biologicals. The mixed vaccine, though losing ground rapidly, still maintains itself, as reference to any recent catalogue will show. They rival the fifty-seven different varieties of the well-known pickle house. They are not the death dealing agents against infection that our early hopes expected.

Another activity of this monster of polypharmacy is in the field of organotherapy where the pluriglandular product is being more and more exploited. Our knowledge of endocrine disturbances is not likely to be advanced by the indiscriminate use of these preparations, the action of which is unknown. Physicians cannot as yet diagnose glandular deficiencies except in one or two well-known instances, and it remains to be shown that feeding of gland products is of any great value with the majority of dried substances with which the profession is being flooded. The literature of some commercial houses and elaborate brochures with such titles as the hormotones, progress in rejuvenation, interstitial bulletins, surveys of organotherapy, containing the most elaborate jargon of pseudoscientific evidence and testimonials floods our desks. From the mass of literature and samples broadcasted by one firm, it is easy to believe that advertising bills amount to forty or fifty thousand dollars annually as has been shown recently to be the fact.

The next field for exploitation is that of synthetic chemicals. A new hypnotic is made by some reliable house and for a few weeks and months its use and distribution is pushed to the limit. The market is soon captured if enough money, men and samples are put into the field, but within a very short time other manufacturing chemists have gotten into the field with similar products with "catchy" trade names. The new product is the best ever produced; it produces "natural sleep." Colloidal preparations of heavy metals are now trying to raise their heads and appear as the super drugs.

The craze for intravenous therapy is capturing the profession, though in most instances the results are not controlled and there is little if any real evidence to prove that the intravenous method has any advantages over the oral route in the

majority of drugs used. Again take up a recent catalog and see the list of motley preparations, each one with some definite indication and a careful description of its curative properties.

Little need be said here of the activity of the electricians in selling their wares to the profession. The mushroom-like growth of their business and the crowding of offices and hospitals with therapy machines is ample testimony to their commercial adeptness. Not only do they enter the field with detail men, but they are now active in organizing medical societies and dining the physicians, and sending out lecturers to give the profession post graduate instruction in the science and art of healing by this or that method.

The Standard Oil Company should come in for a word. Not content with furnishing the energy for our motor cars and making the wheels of our machinery revolve smoothly, they insist upon the necessity of lubricating almost every intestinal tract in the land. Next to the Standard Oil billboard is one calling our attention to the necessity of making our bread and our bowels rise to the tune of Fleishman's Yeast.

The best pharmaceutical houses are not altogether free from this species of literature. Their brochures are more elegant, and are frequently adorned with some work of art depicting medicine in the olden time, something that generally intrigues our interest at once and leads us into further persual of the tract. Again the picture of Pasteur, or Lord Lister, or Claude Bernard or some lesser light meets our gaze and captures our attention. How the soul of Pasteur would revolt at the use of his name and physiognomy! More recently a picture of Moses on the mountain side receiving the tablets of the law has been used to call attention to a treatment for piles! No expense is spared in the decoration of this insidious literature. Elaborate drawings are shown in color depicting the diseased organs whose pathology fades away under the magic of some new preparation of bile salts or some new antiseptic.

Constipation, cancer, obesity, hypertension are at present kings of this large mass of literature; no less than one hundred and twenty-five separate bulletins being received in a period of a few weeks. The monthly publications are rivalling in some instances the legitimate medical publications, giving attractive abstracts of current literature chosen with apparent impartiality and with no obvious intent. They should all go into the waste basket, but I am afraid do not. If this literature did not pay, the commercial houses would not use it.

Who more than the doctor hurls invectives upon the layman who falls a victim to a cult or a quack? How we do among ourselves with a "holier than thou" attitude inveigh against the gullible public, always ready to run to the newest cult and fad in those fields of medicine which are "extra territorial".

Put the shoe on the other foot and see how it fits. Who is more gullible in the eyes of the impartial scientific observer than the busy practitioner, whose imagination is captured and whose credulity is imposed upon by a well worded advertisement, or a clever detail man who persuasively converses upon some subject little understood, tells of his own experiences as a chronic sufferer who has been completely relieved and who as he leaves the office, in a stage whisper says, "Just try it in Neurosthenia and Impotency and watch the results." He then hands you a bottle and is off to his next victim.

We might as well face the fact that we are not supermen, we are ordinary mortals, but we have one advantage. Our training should enable us to "watch our step", and our organization is doing everything it can to help us. Soon, however, this new polypharmacy will increase its hold upon the profession much to its harm be it said, both in the eyes of the public and in its own interest. Already in the field of medical literature its influence is far from wholesome.

Even in our medical meetings, which derive so much income from their commercial exhibits, the situation needs study and constructive thought. Would it not be to the immense advantage of the profession to ask the A. M. A. to prepare the commercial exhibits for our state meetings? The council on Pharmacy and Chemistry could cooperate with the new council on Physiotherapy and with a council on Medical Publications to furnish exhibits. There could be brought together a careful selection of the new drugs which have had adequate clinical trial in addition to their selection because of intrinsic merit; an exhibit showing the use and value of biologicals with a careful selection of samples (unlabeled by the manufacturer); an endocrine exhibit; an exhibit of instruments of precision, modern laboratory tests and physiotherapeutic apparatus. Together with all these should be put in scientific exhibits of experimental pathology, x-ray diagnosis and

other important fields of research; also a careful selection of medical literature of notable worth and achievement, chosen by a council of impartial judges.

There can be no more important work than a constructive effort on the part of the medical profession to emancipate itself from commercial exploitation, which is such an unwholesome adjunct to every medical meeting, detracting and disturbing as it is to the more wholesome "brain dusting" which we all need.

SUMMARY

In addition may we cite a few simple rules and guides for the general practitioner to follow:

1. Learn to know the use of and indications for a few of the well known classic remedies, such as digitalis, iron, arsenic, mercury, the iodides, strychnine, and opium.
2. Get your information of new drugs from the Council on Pharmacy and Chemistry—New and Nonofficial Remedies. Read the whole report and watch for such remarks as this one under "Benzyl Benzoate," "Extensive Clinical trial has not justified early experimental hopes." Drop the drug there and have nothing more to do with it until further word comes out of the Council on Pharmacy and Chemistry.
3. Write into the Council for information about proprietaries and drugs with catchy trade names.
4. Watch the Journal of the A.M.A. for carefully controlled clinical trials. Do not trust your own experience or judgment; your practice is entirely inadequate for scientific conclusions and is without proper control.
5. When at medical meetings attend the scientific sessions and listen; wait for the discussion of papers and take part in them.
6. In using drugs do not use them intravenously unless the oral route is impossible.
7. In using drugs make sure of an active one and stick to it. Do not change to another preparation at the request of a salesman.

And in conclusion we may paraphrase a remark of Osler's—"A room fitted with a laboratory, the necessary chemicals and a microscope is a better investment in the long run than one with a few machines."

The Roentgen Ray as an Aid in Gastroenterology: Cases Illustrating Difficult Diagnostic Problems Solved*

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La Crosse

This paper is presented as a light diversion between the scholarly lectures being presented today, and is simply a few case reports with illustrations to emphasize the importance of modern roentgenology in the diagnosis of gastroenterological problems.

The Graham-Cole test has largely eliminated guess work in the differential diagnosis between gallstones and angina pectoris. It has simplified the diagnosis in Type IV gall bladder disease, or chronic dyspepsia due to cholecystitis. Rarely is the exploration of a gall bladder justified in this day of the Graham-Cole test combined with Lyon's drainage and competent study of the biliary cytology.

Case 1. (Fig. 1.) *Solitary Cholestrin stone.* Hydrops of gall bladder. This patient suffered from dull dragging pain in the upper right quadrant with dyspepsia of one year's duration. A recent severe attack of pain was considered possibly angina pectoris because of location of pain in the left chest, pulselessness, and prostration. She had a palpable, tender gall bladder. Note the good emptying despite presence of stone. (Fig. 2). Operation confirmed the diagnosis.

The next two cases illustrate the chronic dyspeptic with gall bladder disease.

Case 2. *Diverticulum* of the gall bladder. Had attacks of vomiting, bloating, belching and nausea for the past three years and heavy distress in the lower abdomen. Physical examination was normal. Barium studies suggested perihepatic flexure adhesions. In the roentgenogram eight hours after intravenous injection of iodekon, note the angle necessary to get the gall bladder shadow thrown off the shadow of the vertebrae. (Fig. 3). Roentgenogram one hour after fat meal shows good emptying and concentration. The diverticulum was still present. Operation was refused.

Eusterman[1] in a study of 27 benign tumors of

*Presented before the State Medical Society of Wisconsin, Madison, September, 1926.

Fig. 1. Eight hours after injection, showing single large cholestrin stone.

the stomach, states that patients with large gastric filling defects are often refused operation. Very careful study of such defects before the fluroscopic screen will sometimes change despair to hope.

Case 3. *Polypoid adenoma of stomach.* This man, age 64, was run down and anemic for the past year; had dizzy spells, and had lost seven pounds of weight. Physical examination was normal except for pallor, hemorrhoids and arteriosclerosis. Blood count showed marked secondary anemia. The icteric index was 4. Fasting gastric contents yielded 20 c. c. bloody, slimy fluid, no Boas-Oppler bacilli or lactic acid. No free HCl. was present after test meal. Stools were positive for occult blood. Barium studies repeated three times showed constant defect in the fundus of the stomach, occupying slightly different positions and definitely slightly movable to palpation; no six hour residue. Pre-operative diagnosis was polyp of the stomach, question of carcinoma. At operation there was found a large, movable, soft, ulcerating polypoid mass with wide base not infiltrating beyond the mucosa, attached to the greater curvature of the fundus. There was no glandular involvement. The mass was easily excised. Microscopic examination showed carcinomatous degeneration of a mucous polyp. In one month the patient had gained twenty-three pounds.

Taylor[2] has written the classical article on anomalous bands and kinks causing sub-obstruction of the duodenum. To Halpert[3] we owe a masterly exposition of the anatomy of sub-obstruction of the duodenum by the mesenteric pedicle and the middle colic artery. Pre-operative diagnosis in these cases is rare, but is absolutely necessary, as often the evidence of sub-obstruction of the duodenum is less evident to the exploring surgeon than before the fluroscopic screen. Thus it may be missed without careful roentgen ray study of the duodenal function. The French fluroscopists are the keenest in the detection of these lesions[4,5] and to my training with them I am indebted.

Case 4. *Obstruction* of second portion of duodenum due to kink and band. This patient suffered from pain in the epigastrium for one year with vomiting four or five minutes after meals, night distress and hematemesis. He obtained no relief on ulcer regime. Physical examination was normal. There was motor meal retention. After a test meal, free HCl. was 71, total 105. Stools were negative for occult blood. Barium studies: stomach and cap were normal, no six hour residue was present, second portion of the duodenum was greatly dilated. The barium seemed to accumulate for a short time in the region of the mesenteric pedicle, and then a very active anti-peristaltic wave rushed the barium back into and distended the cap. The stomach emptied well in spite of the hold-up. With each anti-peristaltic wave in the second portion of the duodenum the patient belched. At operation a wide band of peritoneum held the first inch of the jejunum upward and to the right, producing an acute kink. After section, the jejunum assumed its normal position. No evidence was found of ulcer. Twenty days after operation the duodenum emptied normally. The patient reported well nine months later.

Case 5. *Duodeno-cholecystic band.* Pre- and post-operative duodenal sub-obstruction in region

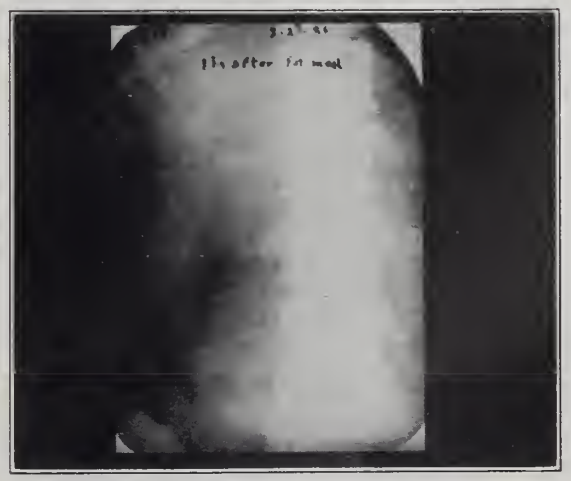

Fig. 2. One hour after fat meal; fair emptying.

of mesenteric pedicle. For fifteen years this patient had spells of cramps in the epigastrium, and nausea suggesting gall bladder attacks. Eight hours after iodekon intravenously a roentgenogram shows the gall bladder bent inward toward the spine, of good intensity, and emptying fairly well. It shows good concentration one hour after fat meal. (Fig. 4). Barium studies showed a cap defect with the gall bladder still faintly visible twenty-four hours later, bent over in juxtaposition to the cap defect. There was also noted a stasis, in the second portion of the duodenum in the region of the mesenteric pedicle. (Fig. 12).

At operation a band was resected which stretched 3 cm. long between the pylorus and fundus of the gall bladder. The gall bladder and the duodenum otherwise appeared normal. No evidence of any other cause for sub-obstruction could be found. But after operation the patient still complained bitterly of burning, gas, and belching immediately after meals. Gall bladder series now revealed the gall bladder in normal position (Fig. 5), emptying better than before. However, barium studies still showed the same duodenal stasis. The patient was now put on a bland diet. He returned five months later, better, but still complaining of pain in the epigastrium with much belching. At this time he had moderate six hour gastric and duodenal residue with stasis still evident in the region of the mesenteric pedicle. Duodeno-jejunostomy was refused, so he was advised to try wearing a corset. The anomalous band evidently did not explain the duodenal sub-obstruction several inches beyond the attachment of the band.

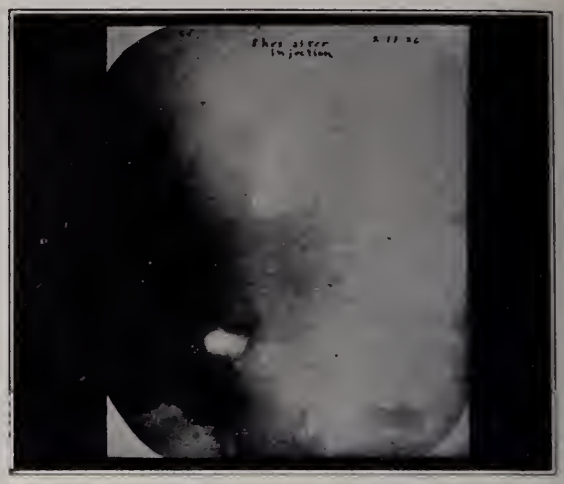

Fig. 5. Visualization after resection of band. Eight hours after injection; gall bladder now in normal position.

The next case demonstrates the value of barium studies in all cases of chronic diarrhoea. This patient had recently seen three physicians who must have made the most precursory of examinations, since not even the correct chest diagnosis had been made.

Case 6. *Tuberculosis of cecum and lungs.* Appendectomy had been performed four years ago. She gave a history of cramps, diarrhoea, tenesmus, cough and loss of weight. Signs of moderately advanced tuberculous activity were discovered at both apices. A large sausage shaped tender gurgling tumor could be felt in the right lower quadrant. Barium studies: stomach and duodenum were normal. The head of the six hour column was in the descending colon. The cecum was al-

Fig. 3. Eight hours after injection; diverticulum of gall bladder. Probably due to adhesions.

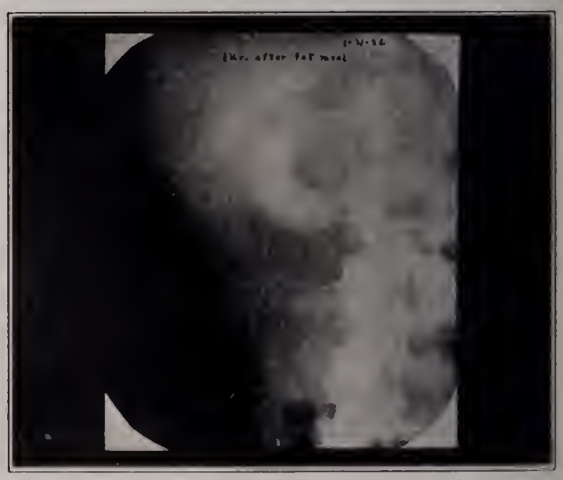

Fig. 4. One hour after fat meal. Fair emptying and concentration.

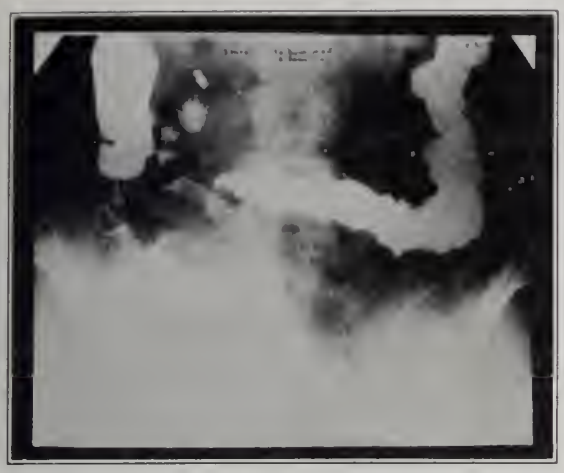

Fig. 6. Cecal intolerance. Barium present proximal to cecal lesion in the ileum and distal to the cecal lesion in the ascending colon. Thirty-hour head of column, twelve-hour tail of the column.

most empty. A large twelve hour ilial residue was present. (Cecal intolerance). (Fig. 6).

Barium enema caused colic; haustration was found poor in the transverse colon and cecum. The filling defect in the cecum was confirmed. The patient was greatly improved by nine months of sanitarium treatment and is now back at work.

In the diagnosis of the cause of pain in the right lower quadrant outside acute appendicitis we should turn to the roentgen ray invariably for possible explanation. An English writer has recently said "Pain in the right lower quadrant is never appendicitis". This statement is too didactic, but always beware of the diagnosis "chronic appendicitis". Do not forget spastic constipation, colitis, mobile cecum, cecal stasis so often associated with cecal and hepatic flexure ptosis, Jackson's membrane, Lane's kink, ureteral stricture and stone, pyelitis and pelvic disease in women.

De Martel and Antoine[6] have recently written a most excellent monograph on the "Mechanical Syndromes of the Lower Right Quadrant", which throws a vast light on the reason why buttonhole incision appendectomies for chronic appendicitis are usually therapeutic though not financial failures.

Case 7. *Chronic adherent appendicitis.* This case was treated for sixteen years under various diagnoses, dyspepsia, ulcerated duodenum, neuresthenia, constipation, and has worn a sacroiliac belt for pain in the right sacral region for twelve years. Barium studies: stomach and cap were normal. The appendix was retrocecal and to the right, holding the base of the cecum kinked upward and to the right. There was relatively small shift with only slight change from lying to standing position. There was definitely localized tenderness over the appendix and 24 hour retention. Findings were confirmed at operation. He has now discarded his sacroiliac belt.

Case 8. *Kinked adherent chronic appendicitis.* This patient had three attacks in four months of generalized abdominal pain with vomiting and purpura. Otitis media accompanied the last attack. Physical examination showed slight tenderness over McBurney's point with some spasm. Barium studies showed transient pylorospasm, kinked appendix with twenty-four hour retention, marked localized tenderness, (Fig. 7). The kink is fixed, failing to fall in relation to the bony landmarks on shift to standing position. (Fig. 8). Findings were confirmed at operation. There was acute inflammation present.

Case 9. *Irritable colon* with spastic constipation (chronic appendicitis ruled out). This pa-

Fig. 7. Thirty-hour head, twenty-four hour tail of column. Lying position.

Fig. 8. Standing position. While the cecum has sunk downward the kink remains relatively fixed in relation to the bony landmarks.

Fig. 9. Right ureteral stricture with hydronephrosis.

tient was referred by his local doctor for an appendectomy because of slight tenderness over McBurney's point. He also had epigastric pain about 4 P. M., with food relief, vomiting and belching. He had never had an acute attack of appendicitis. Spastic constipation syndrome present. Physical examination showed a hyposthenic young man of sedentary habits, with slight tenderness in the right lower quadrant. Barium studies: stomach low even for habitus, cap normal. The appendix lay in normal position, falling over the brim of the pelvis and was freely movable. The cecum was very freely mobile. Slight tenderness was noted over the base of the appendix. The patient was put on a spastic constipation irritable colon regime and reported five months later a gain of 15 pounds and perfect health.

Case 10. *Ureteral stricture.* This patient had had a course of chiropractic treatments at the "fountain head" itself, and what was worse, had had a useless appendectomy by a surgeon who had not taken the trouble to properly investigate the case. There was no relief of his pain in the right side until his ureteral stricture was dilated. (Fig. 9).

Case 11. *Ureteral stone.* This young woman had endured three laparotomies; first for gall bladder disease, second for adhesions, third for removal of ovary and appendix but continued to have attacks of pain in the right lower quadrant until a ureteral stone was discovered and removed.

One must never forget that cramps in the right side may be due to cecal contraction in attempts to overcome an obstacle, perhaps a functional spasm in the descending colon, perhaps an organic stricture in the distal colon as in the following case:

Case 12. *Carcinoma at the splenic flexure.* This patient was sent in as a possible gall stone colic, but the Graham-Cole test revealed a normal gall bladder. There was present obstipation with severe cramps in the upper right quadrant of three days' duration. Physical examination showed slight fullness in the lower abdomen and tenderness over the colon, especially in the left upper quadrant. The cecum seemed dilated. Barium studies revealed dilatation of the second and third portions of the duodenum and jejunum with visible peristalsis in these parts. At six hours most of the barium was still in the ileum. At thirty hours the head of the column was held up at the splenic flexure. A barium enema was now given to meet the head of the column and revealed the narrowing shown in the roentgenogram. (Fig. 10). Findings were confirmed at operation. The patient is now well nine months later.

The necessity of a complete gastroenterological examination is revealed in the following protocol.

Case 13. *Diverticulosis.* The admittance diagnosis was gall bladder disease and the Graham-Cole test failed to show any filling, confirming this impression. But more careful questioning

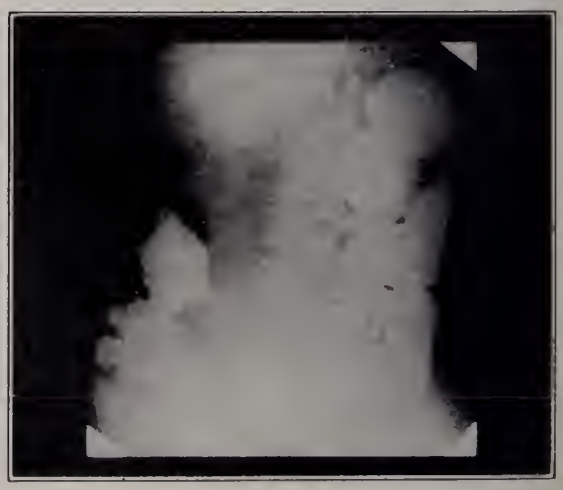

Fig. 10. Barium enema given to meet head of obstructed column. Filling defect at splenic flexure.

Fig. 11. Shadow interpreted as multiple faceted gall-stones. None found at operation.

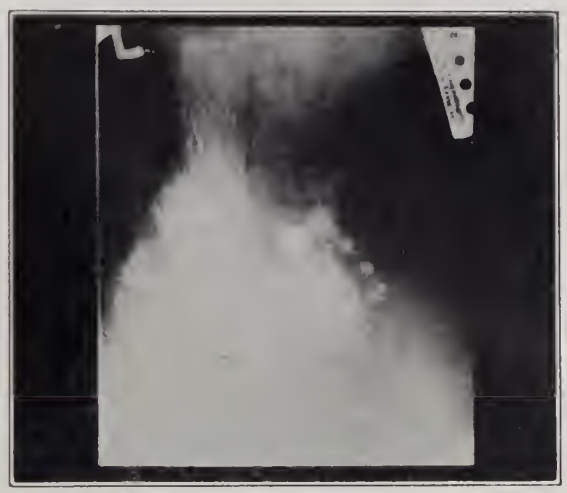

Fig. 12. Carcinoma of duodenojejunal flexure, causing almost complete obstruction found at operation. Barium studies showed no evidence of any duodenal pathology.

uncovered a typical history of irritable colon syndrome with spastic constipation, hard ball stools alternating with diarrhoea. For the past three days she had had severe abdominal cramps chiefly in the right side of the abdomen and a more constant boring pain in the right lower quadrant, accompanied by much bloating and belching. Stools showed no pus but some mucus. Barium studies gave evidence of reflex gastric irritability. Three meals in the colon showed a normal appendix, a spastic tender transverse colon with canalization marked especially at the splenic flexure and in the descending colon. Barium enema revealed five diverticuli. Diverticulosis is often best revealed by a plate taken after defecation. The patient improved on irritable bowel regime.

My last case is to illustrate that when all is said and done, a careful history and period of observation is ninety per cent of gastroenterological diagnosis. Dr. George Dock used to tell his house officers that when he died he wanted this epitaph on his tombstone, "This man examined stools".

Case 14. *Carcinoma of duodenum.* This roentgenogram is shown to illustrate how one might be led astray. The diagnosis was naturally gall stones (Fig. 11), but the patient's history and physical findings denoted simple anemia of four months' duration, demanding transfusion. She had had vague epigastric pain, not related to meals. The barium studies report was, "negative gastroenteric tract (Fig. 12); shadow of multiple faceted gall stones." (Fig. 11.) She continued to have bleeding in her stools over two weeks' observation, and this was the indication for operation and not the gall stones, which were considered incidental. At operation an almost obstructing carcinoma at the duodeno-jejunal flexure was found. There had been no evidence clinically nor on barium studies of duodenal obstruction. Surprising to say, there were no gall stones! The patient died of post-operative gastric dilatation and shock.

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PREVENTION OF CONTRACTURES FOLLOWING INFECTIONS OF HAND

Sumner L. Koch, Chicago (*Journal A. M. A.*, April 16, 1927), asserts that contractures following hand infections may be reduced to a minimum if (1) drainage incisions are made with due regard for important anatomic structures; (2) secondary infection is not added to the primary infection; (3) hot dressings are dispensed with early in the course of treatment and replaced by the intermittent use of the sterile arm bath and dry heat; (4) movements of the fingers and hand are initiated as soon as the acute symptoms of infections have subsided, and (5) during periods of rest the hand is immobilized in the position of function.

Jaw Fractures; the Value of Orthodontic Appliances to Immobilize

By M. N. FEDERSPIEL, M. D.,
Milwaukee

Fractures of the maxillary bones frequently involve complications of a complex nature. This is largely the result of the peculiar anatomical relation of the teeth and their usual pathological manifestations. Clinical findings pertaining to the teeth and their investing structures prove that disease is rarely absent here. Tooth-decay, gangrenous pulps, chronic pericementitis, and periapical infections are so frequently a constant pathological phenomena that their absence is a rarity in the civilized human being.

Naturally, a fracture of the jaw bone in the region of the teeth may give rise to serious complications, often producing alarming symptoms. The result may be loss of anatomical structures with marked deformity and impaired function and sometimes a fatality.

In order that these serious and complex pathological changes may be minimized in treating jaw fractures, it is necessary to fully comprehend the anatomical structures of the teeth and jaws and adjacent structures. Also to have a clear understanding of histopathology and a knowledge of surgical and orthodontic principles.

Strange as it may seem, fatal results following jaw fractures even when of a complex nature, are few. Statistics prove that the mortality barely reaches 1 per 1000 if we exclude cases of severe hemorrhage and cases where the general condition is poor from complications such as pyemia of buccal origin and septic pneumonia.

Before attempting the treatment of jaw fractures it is advisable to consider the anatomical relation and physiological peculiarities of the teeth and jaws. Occlusion of the teeth is important. When the teeth occlude normally, all the inclined planes of the cusps are in correct relation. A deviation from the normal is considered a malocclusion.

Surgeons who are not familiar with the anatomical relation of the teeth should realize that jaw fractures differ considerably from those fractures which the general surgeon is usually required to treat. Although many people have malocclusions, still mastication may be performed with a great degree of efficiency. If a fracture occurs in such a case, dental adjustment of the broken bones should be such as to restore the original relation of the teeth, in order to insure mastication after healing has taken place.

While efficient mastication is dependent on dental adjustment, rigidity of the broken bone is also a factor and both should be considered of paramount importance. If, however, a fracture of the jaw is accompanied by loss of bone substance, especially in the mandible, one is confronted with the serious consideration of choosing either one or the other. In such a case, to obtain a correct relation of the teeth by dental adjustment, the fragments of bone must remain apart, resulting in a pseudo-arthrosis. To obtain rigidity, the fragments must be held together, resulting in a deformity. Personally, I prefer the deformity to pseudo-arthrosis. In most cases the deformity is slight and further adjustment of the teeth can be obtained by orthodontic care or prosthetic restoration.

Patients suffering under the disability of pseudo-arthrosis are at a greater disadvantage than those with a rigid mandible short of sufficient bone substance and accompanied by extreme malocclusion. Yet with this deformity, the various movements of the mandible with its duplicate articulation, permit mastication of considerable efficiency.

In times of peace, dento-facial mutilations are rare—consequently the surgeon seldom treats cases where there is loss of bone substance. The usual cases in civilian practice, though of a severe nature at times, rarely manifest loss of bone substance sufficient to cause mutilation.

Fig. 1. A compound fracture between $\overline{|3}$ and $\overline{|4}$.

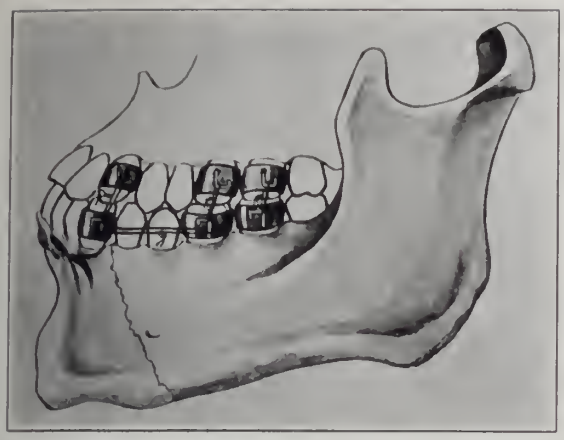

Fig. 2. Illustrates immobilizing jaw fracture. Bands with hooks are cemented to the teeth and by wiring the broken bone is stabilized.

When treating fractures of the jaws it is necessary first, to place the broken parts in correct anatomical position. Second, to immobolize the bones to obtain rigidity. Third, to prepare for complications and treat accordingly when they occur.

When attempting to replace the broken bones in correct anatomical position, it is important to study carefully the relation of the teeth. The restoration of the teeth to their former position in occlusion will determine the correct relation of the jaws.

Radiographs are of great aid, not only in making it possible to visualize the line of fracture, but also in showing any existing pathological conditions within the jaw structures. Infected teeth, broken down, degenerated roots, cysts, and impacted teeth will frequently be found within the line of the fracture. If this is the case, surgical interference is at once necessary in order to remove any pathological condition that might give rise to complications. Gingival pockets should be carefully swabbed with a 10% solution of chromic acid.

ORTHODONTIC PRINCIPLES

Since the introduction of orthodontic principles and practice, oral surgeons are adopting its usage to make and fit bands and appliances for the purpose of immobilizing fractures of jaws that possess a sufficient number of teeth to permit the execution of these principles.

When the technic of making and fitting orthodontic appliances to the teeth is mastered, immobilization of the jaws is comparatively an easy matter and is far more practical than any other method that has been heretofore used.

Especially is this true in fractures of the mandible. The number and variety of the movements which this bone possesses is of a peculiar physiological interest and yet its capacity for immobilization is greater than any other bone in the body.

By attaching bands with hooks and alignment wires to the teeth and firmly ligaturing the two arches together with copper wires, the mandible becomes immobilized and renders possible the rapid consolidation of the fracture. While this debars mastication, feeding is not prevented. Liquids can be sucked through the dental interspaces. If, however, the teeth are so close together that fluids cannot pass through, then it is advisable to extract one molar (before immobilization of the jaws) to permit drawing liquids through the open space left after the removal of the tooth. Frequently there are open spaces as a result of teeth previously lost or the retromolar spaces may permit a sufficient opening to draw fluids into the mouth to nourish the patient while the jaws are fixed.

ILLUSTRATIVE CASES

Several months ago a young man, 21 years of age, fractured his mandible while playing football. He was in good health and possessed an excellent set of teeth, free from caries and gingivitis. The occlusion was in correct anatomical relation and the facial lines were harmonious. He was sent to a local hospital where an attempt was made to immobilize the fracture with a crossed bandage. While this method seemed to rest his jaw, there was a noticeable shifting of the mandible with the

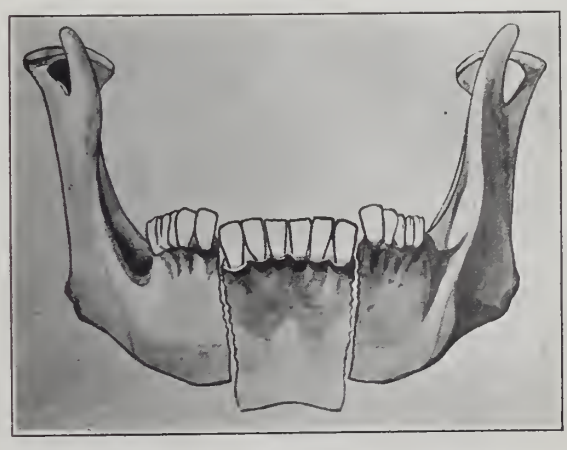

Fig. 3. A bilateral compound fracture of the mandible.

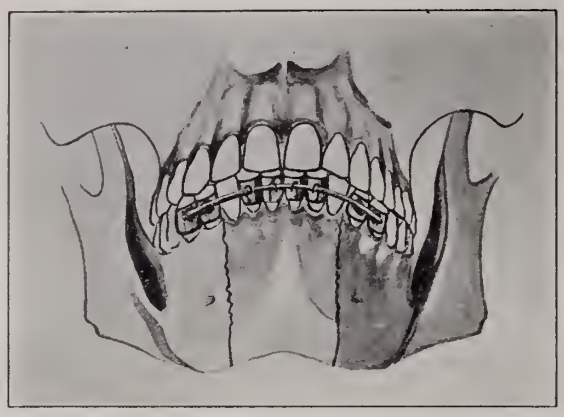

Fig. 4. Illustrates the value of an orthodontic appliance to immobilize the broken mandible.

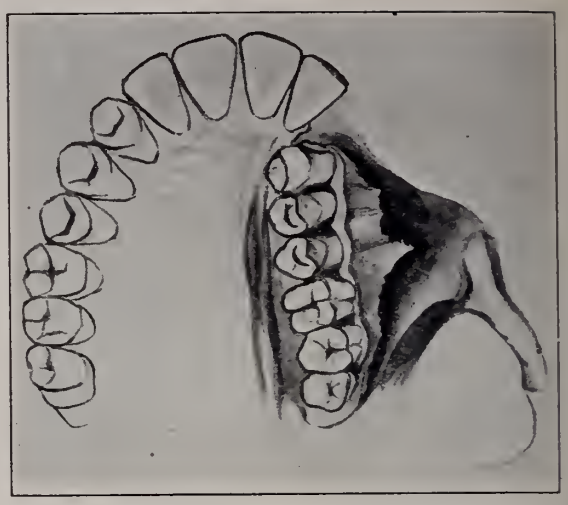

Fig. 5. A fracture of the left maxilla exposing the antrum. The | 345678 with the alveolar process was shifted inward.

result that the dental arches were in marked malrelation. Fearing that this condition might become permanent, his physician advised intraoral immobilization.

The third day following the accident I was asked to assist in the treatment of the case.

Figure 1 illustrates the compound fracture of the mandible between $\frac{|}{1\,|\,34}$.

In order to obtain room between the teeth to permit bands to be fitted, the teeth were carefully wedged apart for 24 hours with rubber pads. Then the mandible was anesthetized by blocking off the third division of the fifth nerve. This permitted manipulating the jaw and operating on the teeth without any discomfort to the patient. Seamless bands (german silver) with hooks were fitted to $\frac{3\,|\,67}{3\,|\,67}$ and wired as illustrated in Figure 2. The jaws were securely immobilized. Feeding was maintained by sucking liquids through the open retromaxillary spaces.

The teeth could be brushed on the labial and buccal sides and the mouth washed with a 50% solution of peroxide of hydrogen. The solution was sucked in and forced out through the interproximal spaces. The patient made a rapid recovery and four weeks later the appliances were removed and the teeth were thoroughly cleaned. The relation of the teeth was perfect.

Figure 3 illustrates a bilateral, compound fracture of the mandible. The central portion supporting $\frac{|}{321\,|\,123}$ was pulled down by the action of the anterior belly of the digastricus and the geniohyoidens muscles. The patient, a young lady, had been injured in an automobile accident. Here

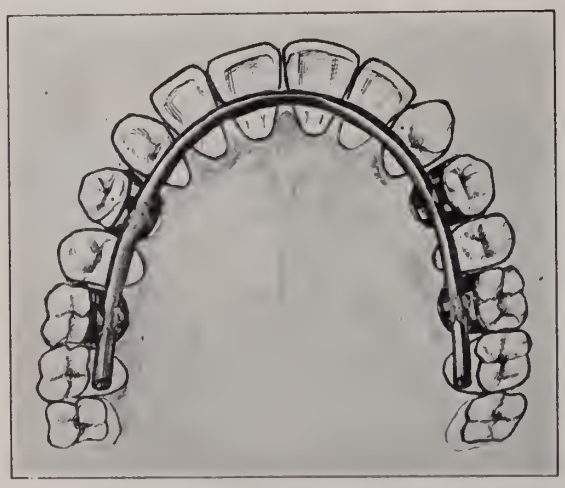

Fig. 6. Showing a 15 gauge German silver wire soldered to bands cemented to *64 | 46*. This appliance stabilized the fracture as | illustrated in Fig. 5.

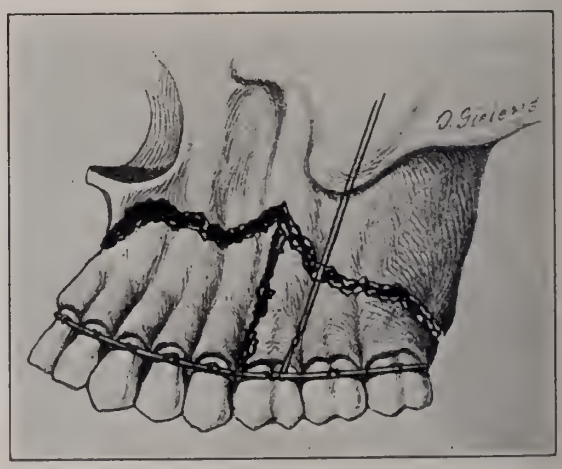

Fig. 7. Showing the maxilla loose from its attachment. Notice alignment arch gauge 15 wire to all the teeth. The wire attached to the arch at the first molar was passed through the cheek. See Fig. 8.

again was a case of beautiful teeth necessitating accurate and careful attention to fix the fracture so that there would be a normal alignment of the teeth in correct anatomical occlusion.

Bands were fitted on the following teeth $\frac{|}{5\,4\,2\,1\,|\,1\,2\,4\,5}$, and hooks were soldered to the bands on $\frac{|}{2\,1\,|\,1\,2}$. An alignment wire (15 gauge german silver) was shaped to rest against the labial surface of the lower anterior teeth and soldered at each end to the bands on the bicuspids, and cemented in place. The displaced central portion of the mandible was then gently forced into normal position. The bands with hooks, on the incisors, were cemented into place so that each hook rested on the alignment wire. This simple appliance firmly immobilized the fractured bone. See Figure 4. The patient could move the mandible during light feeding and talking without any discomfort. This form of appliance eliminates the necessity of bandaging. Cleansing the teeth by brushing and washing the mouth with a suitable antiseptic could be done while consolidation of the broken bones took place.

These two cases illustrate the advantages of immobilizing fractures of the mandible where there is a sufficient number of teeth to permit the fitting and cementing of bands and orthodontic appliances.

Fractures of the maxilla likewise can be immobilized with orthodontic appliances in order to safeguard against a malocclusion after healing has taken place. Figure 5 illustrates a fracture of the maxilla of a young woman. The canine bicuspids and molars on the right side, with their alveolar process, were torn loose and shifted lingually. The antrum was opened in the region of the alveolar cul-de-sac. The antrum was thoroughly irrigated in order to wash out the blood clots and the broken bone was forced into normal position. Bands were fitted to $\frac{6\,4\,|\,4\,6}{|}$. To these bands an alignment wire (gauge 15) was shaped to rest against the lingual surfaces of the maxillary teeth and soldered to the bands, Figure 6. The appliance was then cemented into place. This simple and efficient appliance immobilized the fracture, permitting consolidation to take place.

A fracture that will cause a complete displacement of the maxilla from its attachments sometimes ocurs, as is illustrated in the following case.

Mr. F. W., 28 years of age, while driving his car at a terrific rate of speed, lost control of the auto and struck a large tree. The force of the impact caused his face to strike against the steering wheel, tearing the entire maxilla loose from its attachments. Figure 7. Since the accident happened 25 miles from the nearest physician, there was considerable delay in giving the patient first aid. After several hours he was taken to a local hospital where he was given the usual care to overcome the symptoms of shock which were now manifest. As there were no provisions at the hospital to enable the surgeons to immobilize the multiple, compound fracture of the maxilla, nothing was done except to repair the lacerated lip and to keep the mouth irrigated and cleansed.

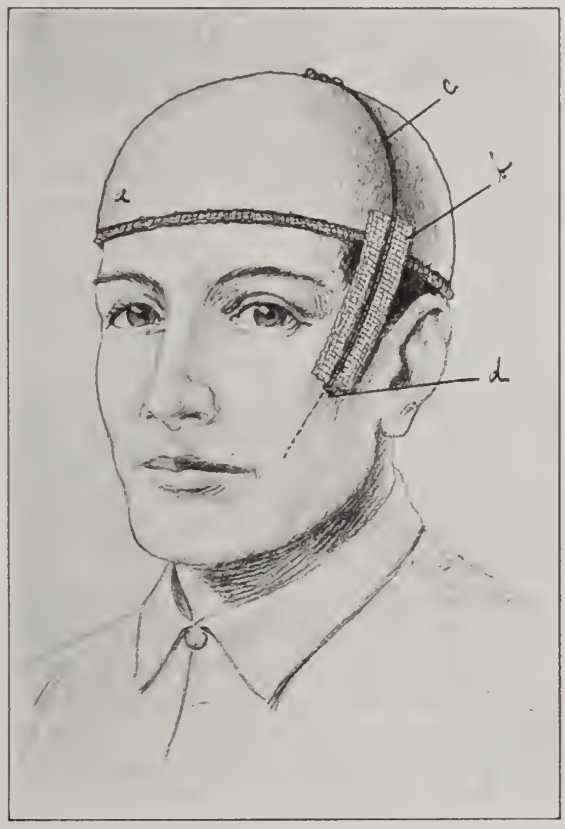

Fig. 8. A. Showing plaster of paris cap.
B. Gauge pad.
C. Copper wire.
D. Opening into cheek.

One week following the accident the patient had sufficiently recovered from the shock to be transferred to St. Mary's Hospital, Milwaukee. He was admitted on October 21, 1926, and this same day I saw the patient for the first time.

Examination. The patient had a marked ecchymosis involving the entire face, and the lips were badly swollen and bruised. The maxilla was displaced downward and backward, exposing both

antrums in the region of the alveolar cul-de-sac. The vomer was detached from the palate at their junction. There was a vertical fracture between $\frac{56}{}$, connecting with the horizontal fracture above. The crowns of $\frac{21|1}{}$ were broken near the incisal edge. There was also a vertical fracture between $\frac{1|1}{}$ which joined with the open space caused by the separation of the maxilla from the vomer.

The x-ray findings were as follows: comminuted, compound fracture of both superior maxillary bones. Nasal, orbital and outer walls of antrum all show fractures.

On October 23, 1926, under ether anesthesia, an alignment wire (gauge 15) was fitted to the upper arch to cover the outer surfaces of the teeth. All of the upper teeth were then ligated to this base wire which firmly immobilized the broken maxilla and kept the teeth in good alignment. The maxilla was then manipulated until it was forced back into its original position and held there by wires attached tc $\frac{5|5}{}$. The ends of the wires were then drawn through the cheeks at the junction of the alveolar cul-de-sac and fastened over the head, which had been previously covered with a plaster of Paris cap. Figure 8. This method firmly immobilized the jaw in correct position.

Post-operative care. The oral cavity and the nasal passages were cleansed three times daily and the antrums were irrigated daily for a period of one week. No complications developed and the patient made an uneventful recovery. After five weeks he was dismissed from the hospital and advised to have dental care at a later date.

Loose Bodies in the Knee Joint and Their Surgical Removal*

By VICTOR F. MARSHALL, M.D., and CLARENCE C. REED, M.D.
Appleton

John Hunter (12) in 1759 described and demonstrated loose bodies in the knee joint, although it is said that Ambrose Paré successfully removed a loose body from a joint in 1558 (14). They also may occur in the elbow, hip, ankle, shoulder and maxillary joints but far less frequently than in the knee where they often cause distressing and crippling symptoms.

ANATOMY

A knowledge of the structural anatomy of the knee joint is essential for a clear understanding of the pathology and treatment of the condition. The knee joint is the largest and strongest in the body and its strength is largely due to the powerful ligaments which unite its two component bones. As a result dislocations of the knee are rare. The joint between the femur and tibia is built up of two lateral parts. The condyle of the femur on each side articulates with a corresponding depression in the tibia and forms practically a separate joint with a crucial ligament as one of its lateral ligaments. In some of the lower animals there are really two joints in the knee (16).

The patella is a sesamoid bone and is developed in the tendon of the quadriceps femoris muscle. It has two articular facets and the femoral condyles extend forward on their anterior parts where they come in contact with the patella when the knee is flexed. Neither the patella nor the fibula enter directly into the structure of the knee joint.

The *capsular ligament* which is strengthened by tendinous expansions is attached below to the tibial tubercle and above the attachment is muscular. The *internal lateral ligament* is a broad flat membrane and is attached above to the femur, just below the adductor tubercle and below to the tibia below the internal tuberosity. Its deep fibers are joined to the joint capsule and firmly attached to the internal semilunar cartilage and edge of the internal tuberosity. It limits extension. The *external lateral ligament* arises from a tubercle below and in front of the attachment of the gastrocnemius muscle and is attached to the fibula anterior to the styloid process. It consists of two parts anterior and posterior and strengthens the outer aspect of the joint (8). The *posterior ligament* forms the floor of the popliteal space and is composed of the expansion of the semimembranosus muscle.

The patellar tendon extends from the tip of the patella to the tibia but it is not adherent to the joint capsule. The patella and quadriceps tendon do not form part of the knee joint. The two *crucial ligaments* pass from the inter-condylar notch of the femur to the upper surface of the tibia. They are about 3 to 4 millimeters in diameter and intracapsular but extrasynovial. The anterior crucial passes obliquely upward, backward

* Presented before the Outagamie County Medical Society, January, 1927.

and outward while the posterior passes upward, forward and inward. The anterior tends to prevent forward displacement of the tibia while the posterior prevents backward displacement. They also check inward rotation.

The semilunar cartilages deepen the joint. Their borders are thick and centers thin, the external is circular but the internal is elliptical. They are attached by their outer edges to the capsular ligament and inter-condyloid eminence and are in close relation with the lateral ligaments of the joint. The synovial membrane is extensive and has an intricate arrangement. It extends some distance from the joint in front of the femur beneath the extensor tendon and lines the intra-articular surfaces which are not subject to compression. There are several ramifications and diverticulae about the joint (19). This is of great importance in knee pathology.

Movements of the knee joint are flexion, extension and to a less degree rotation, the latter taking place around the axis of the tibia (7).

Etiology and Pathology

Loose bodies in the joints may occur at all ages but more frequently in middle life and rarely in children (6). They occur more often in men than in women and between the ages of 15 and 25 according to Fisher (12). They may be of several forms and varieties. They may be single or multiple, free or pedunculated, laminated or of uniform composition. In size they vary from a few millimeters to several centimeters and may be irregular, rough or smooth. They are most often formed by hyperplasia of synovial tufts with production in them of cartilage and bone.

The so-called *mellon seed type* consists of fibrin and fibrinous exudate and are frequently found in tuberculous joints. At first they are irregular, later they become smooth and flattened out due to joint activity. They usually have a laminated structure and may be single or multiple.

As a result of trauma pieces of the *articular cartilage* may be broken off, but they are frequently attached by a pedicle of fibrous tissue which limits mobility to some extent. They are usually rounded off and are of various sizes and may be single or multiple. Schmidt (17), from an x-ray and anatomical study of the knee, concluded that a jump on an uneven base or sprain with violent bending and forced rotation makes the upper margin of the patella injure the cartilage, whence a loose body is formed. Cysts (11) may also develop in one of the loose semilunar cartilages following trauma.

Loose bodies are a frequent complication of *osteo-arthritis* and may develop from cartilagenous nodules in the synovial villi or fringes. Hypothyroidism is thought to play a part in some cases of cartilagenous proliferation in arthritis. They are lobulated and irregular in shape and consist of calcified cartilage or bone. They may also occur with some more or less general pathological process affecting the joints such as tabes, tuberculosis or acute arthritis (9).

Symptoms

There are three symptom groups, the acute, subacute and chronic (14).

In the *acute type* the onset is sudden and is frequently due to twisting or wrenching. The patient usually falls and there may be temporary locking of the joint, which occurs when one of the loose bodies is caught between the articular surfaces. This produces pain due to stretching of the ligaments, the joint swells and often a synovitis or bursitis results. Usually one attack predisposes other attacks. This type is seen most frequently in athletes and is sometimes called the football or athletic knee.

In *subacute cases* there are recurrent attacks of joint disability following the primary attack, characterized by sudden acute pain, some instability of the joint and swelling. This is often called synovitis, water on the knee, arthritis, etc. Each attack leaves the patient worse off than before so that he finally seeks medical aid.

Usually after months, sometimes years, the joint reaches a *chronic* stage where it does not move fully, it creaks on motion, there is pronounced distortion, sometimes joint effusion and there may be evidence of osteo-arthritis, some neuropathy, tabes or tuberculosis.

Diagnosis

The history and general condition of the patient are important. In addition to local symptoms complained of, the history of trauma or existence of a general disease like tabes, tuberculosis or arthritis is of value in arriving at a diagnosis. The most important loval evidence is feeling one of the loose bodies but repeated examinations may be necessary to do this (10) for they move around readily within the joint, hence the term "joint mice" has been quite aptly applied (15).

The x-ray is of value in some cases especially if some bone is attached to the cartilage as is often the case, but a sesamoid bone in the flexor tendon of the knee should not be confused with a loose body within the joint. Balensweig (2) and also Kleinberg (13) have shown that distending the joint with oxygen is of value in demonstrating the pressure of foreign bodies, although we have not used this procedure in our work.

The *differential diagnosis* between a loose body and a displaced or movable semilunar cartilage is sometimes quite difficult since in both painful locking of the joint may occur. Where there is a loose body fixation is usually only momentary while the locking may persist till reduced in case of a movable cartilage. There may also be a localized point of tenderness at the site of injury where there has been an injury to the cartilage. Furthermore a history of twisting or spraining the joint is common in movable cartilage, but with loose bodies no trauma is necessary.

Other conditions which sometimes simulate a loose cartilage are injury to the lateral ligament, adhesions within the knee, slipping of a tendon, arthritis and intra-articular fracture, but usually a careful history and examination will make the diagnosis clear (5).

Treatment

The treatment for this condition is surgical. Occasionally, under local anæsthesia, the loose body can be held by a needle and the joint opened immediately over it and thus removed through a small opening without having the finger in the joint (4). Usually, however, a wide opening into the knee joint is necessary and several methods of doing this are available (3). The exposure through bisection of the patella first performed by Sir Robert Jones and advised by Warbasse and Albee gives the widest exposure of the interior of the knee joint and also best enables the localization and removal of loose bodies. This method can also be utilized for operations on the synovial sac, cartilages, crucial ligaments and intra-articular fractures of the tibia and femur (20).

The skin incision is about 5 inches in length in the midline or curved laterally and the patella and lower part of the quadriceps tendon are split in the center with a scalpel and then completely divided with a bone saw and osteotome, being careful not to injure the joint. The halves of the patella are then pulled apart as the knee is flexed and the interior of the knee is then well exposed and can readily be explored for the loose bodies which may lie anterior and well up under the quadriceps tendon or laterally or behind the crucial ligaments. The joint should be opened and explored very carefully. After their removal the joint should be flushed out with physiological salt solution and then closed by first suturing the synovial sac with a continous fine chromic catgut suture (subsynovial) and it should have an accurate approximation (1). The quadriceps tendon and patella are held together with chromic gut or kangaroo tendon and the skin is closed with continous plain catgut or silkworn interrupted sutures.

The leg is held in extension for one or two days with a posterior plaster splint. The splint is then removed daily and passive motion to the knee is given. This prevents the formation of adhesions within the joint (18). The splint is kept on for 7 to 8 days and the patient is allowed to walk at the end of the first week.

Illustrative Cases

Case I. Acute type.
Male, age 40. Laborer.

Three months previous to the operations patient had fallen and twisted his left knee. Following this, on many occasions, the knee had locked for several minutes and had become quite painful for some little time following the locking. Past history was otherwise negative.

Examination showed some tenderness over the region of the internal semilunar cartilage but no loose body could be palpated. Otherwise examination was negative.

The knee was opened through a median longitudinal incision and the outer one-third of the interal semilunar cartilage was found to be broken off but it remained attached by a thin pedicle about 2 centimeters long. The fragment was removed and the patient made an uneventful recovery and has remained well for several years past.

Case II. Subacute type.
Male, age 19. Student.

Three years previous patient had a sudden pain in the right knee with locking of the joint which was followed in a few minutes by relaxation. The locking had become more frequent and occurred 2 or 3 times daily. Some swelling of the knee had recently taken place following the attacks. He gave a history of having injured the knee while playing basket-ball sometime previous to the onset of the trouble. Past history otherwise was essentially negative.

The patient was a robust youth and the physical examination was essentially negative except for some swelling and slight relaxation of the right knee. No loose bodies could be palpated but a diagnosis of joint mice was made.

The knee was opened in the midline and two loose bodies the size of almonds were removed. Except for a

slight effusion in the knee after the operation the patient made a perfect recovery and 5 months later was perfectly well.

Case III. Chronic type.
Female, age 51. Housewife.

Twenty years previously patient was thrown from a street car and injured her right knee, which was swollen and painful on motion for some time following the injury. She also had occasional mild attacks of pain and stiffness in the knee from that time until about one year ago when the knee began to give her considerable trouble. It became very painful, creaked on motion and would frequently lock for a few minutes.

Past history was otherwise negative except for typhoid fever and pneumonia in her youth, and a uterine operation in 1907. The right knee was enlarged and relaxed and a movable loose body could be palpated beneath the extensor tendon. Otherwise examination was essentially negative.

The knee was opened in the midline and there was considerable proliferation of the synovial villæ with the formation of spongy masses and some erosion of the median condyle of the femur. There were two joint mice about the size of almonds. The patient made an uneventful recovery and two months later was perfectly well, and has no difficulty in using the knee.

Conclusions

1. Loose bodies occur not infrequently in the knee joint. Its complicated anatomy, the trauma, twists and sprains to which it is subjected as well as the occurrence of general diseases like tabes, tuberculosis, and osteo-arthritis predispose to their formation.

2. Their presence is manifested by locking of the joint, by pain and in time relaxation of the ligaments. They can frequently be palpated or demonstrated by roentgenograms.

3. The treatment is surgical removal, and this is best accomplished by a median longitudinal incision which gives the widest exposure of the interior of the knee joint. Locating and removing the loose body is facilitated by this method. Following the operation, early passive and active motion and having the patient walk within a week or ten days gives the best results.

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SIMPLE METHOD FOR DERIVING FORMULA FOR DIABETIC DIET

A simple method is described by William S. Collens and David H. Shelling, Brooklyn (*Journal A. M. A.*, Feb. 5, 1927), for the rapid calculation of a diabetic diet. All the data necessary are the total caloric requirements of the patient and the percentage of total calories to be given in the form of protein. The caloric requirements are easily obtained from standard tables or charts already described in the literature, such as the Du Bois surface area chart or the Boothby nomographic chart for the prediction of the basal heat production. The advantage of this method is that complicated calculations need not be made. The grams of carbohydrate, protein and fat are read directly in a table.

THE JOURNAL CLINIC

Diagnostic Problems

By L. M. WARFIELD, M. D.,
Milwaukee

In the May issue we presented the history of a white woman, 54 years old, who had rapidly advancing swelling of the abdomen over a period of three weeks and who had previously been well. Slight anemia, irregular fever, and negative physical examination except for distended abdomen filled with blood-stained fluid.

Discussion

Here we have a white woman, 54 years of age, who had always enjoyed excellent health, whose family history was quite negative, and whose illness began rather acutely with some bowel trouble. The vaginal examination was unsatisfactory on account of the distended abdomen. No tumor masses could be felt, and there was nothing in the cardio-vascular system nor in the kidneys to account for her swollen abdomen. It was possible to rule out cirrhosis of the liver as there was no etiological factor present. Tumor of the ovary could not be definitely ruled out because of the fact that examination was unsatisfactory. Tuberculous peritonitis was considered; but it was thought that the age of the woman, the relatively little fever, the lack of increase in the leucocytes, with absence of any pain in the abdomen, were sufficient negative evidence to make that diagnosis improbable. Cardiac disease, renal disease, liver disease, the ascites due to profound anemia, and the end stages of disease of the spleen could all be ruled out. We were left with only the probability that she had a malignant growth, and at her age, it was thought most probable that the growth was retro-peritoneal or ovarian. It was considered justifiable to open the abdomen. This was done. The peritoneal cavity contained about three gallons of blood-stained fluid. The entire omentum was a solid, nodular, injected mass. The parietal peritoneum was studded with tubercle-like masses varying in size from 1 to 10 mm. in diameter. The intestines were also studded with many minute tumor masses. In the pelvis, the tubes, ovaries, and uterus, were replaced by a large mass resembling a collection of grapes. The liver and spleen were perfectly smooth. A piece of the omentum was taken for pathological diagnosis. Examination of the specimen revealed a very cellular carcinoma, the epithelial-like cells showing clumps with here and there a tendency to pseudo-gland formation. The course of the disease was gradually downward. The patient died about six weeks after the operation. No autopsy was permitted. Before death the skin became definitely jaundiced, and bile was found in the urine.

Without a complete post mortem examination it is not possible to say with absolute certainty where the tumor arose. While primary carcinoma of the peritoneal cavity occurs, it is not as common as the secondary growths. These latter come from one of four sources as a rule, stomach, colon flexures, gall-bladder and ovary. This probably had its origin in the ovary for the following reasons: (1) The largest tumor mass was in the pelvis around the uterus; (2) the tumors on the peritoneum were most numerous and largest below the navel; (3) the upper abdomen showed fewer tumors and the liver was free; (4) later evidence of advance upwards was shown by the terminal jaundice.

These multiple carcinomatous nodules often show caseous centers, making the resemblance to tubercles most striking. Macroscopically they cannot be differentiated.

Had a paracentesis abdominis been done the bloody fluid would have led to the strong suspicion that there was cancer of the peritoneum. No therapeutic procedures could have been of any avail when the symptoms began. The ovarian tumor must have been present for a long time and only revealed its presence by its metastases.

A New Case Report

A little girl, 6 years old, was seen complaining of fever, slight stiffness of the neck and frequent urination. The parents were both well but of slender build, and the mother is said to have had

curvature of the spine when she was a child. The little girl has not had rheumatic fever or any evidence of any constitutional disease other than a mild rickets. She had had measles but otherwise had been perfectly well and was a bright well grown child about average size. There was a history of a mild attack of pyelitis about a year ago which cleared up quickly.

About one week before she was seen, while playing on the sidewalk, she fell from her express wagon, striking on the lower part of her back and rolling over on the concrete pavement. This did not seem to produce any disability, but in about three days she had fever and rather frequent urination. There was no evidence of injury to the back. An examination of the urine showed many pus cells and bacteria but no albumin except a faint trace which could have been accounted for by the pus cells. There was fever and rapid pulse and the child was quite restless.

The day before she was seen by me it was noticed that her neck was stiff and there was definite Kernig's sign. The temperature was 104° F. but the child made no particular complaint and once she had vomited suddenly without nausea. She did not sleep very well, but had no night cries, and nothing especially had been noted about the pulse nor had her disposition shown any change.

When I saw her she was lying quietly on the couch. Although she had a temperature of 103° F. and pulse of 120, she did not look particularly ill. She was not irritable, answered questions rationally and had no complaint to make. The head showed evidences of old rickets, the eyes were quite normal, pupils equal and re-acted naturally. There were no glands to be felt in the neck. The neck muscles were definitely stiff, although she could move her head slightly forward and there was no discomfort on raising her by lifting the head. Bruzinski's sign was not definitely present. There was nothing abnormal found in the lungs, heart or abdomen. Bilateral Kernig's sign was present, and the knee reflexes were active but not exaggerated. There was no eruption on the skin. A spinal puncture revealed perfectly clear fluid, under considerable pressure.

That was the problem presented. What was the diagnosis? What was the probable prognosis? The answer will be found in the Journal next month.

Riedel's Strumitis

By WILLIAM J. TUCKER, M.D. and MICHAEL A. GERTZ, M.D.
Ashland

One of the most interesting types of thyroid enlargements that has come to our attention recently, has been the type known as Riedel's strumitis. The close resemblance of this condition clinically to malignancy makes its recognition important as Riedel's Strumitis is very amendable to surgical treatment while carcinoma is not.

This condition, when first seen, would give one the impression of malignancy due to its hard, diffuse consistency together with the pressure symptoms produced. It was first described by Riedel in 1896 as a "chronic inflammation of the thyroid gland leading to the formation of an iron-hard tumor". The etiology of this disease is rather incomplete and whether it is a manifestation of some chronic foci of infection, or follows an acute infection is not known. There is no evidence which would point toward any involvement by tuberculosis, syphilis or any other member of the infectious granulomata group. The microscopical section of our specimen suggested involvement by a virus similar to that producing Hodgkin's disease, according to the report of the pathologist. Bohan reported a case in which the enlargement disappeared after the removal of three teeth with apical abscesses, and assumed that focal infection was an etiological factor. This disease is apparently a rare condition, as a search of the literature revealed only twenty-three cases from 1896 to 1924. It usually occurs between the second and fourth decade of life and is most commonly found in males.

The case under our observation is that of a male, age 48, who stated that he noticed a sudden swelling of his neck about six months ago, which has not at any time been tender or painful and has gradually increased in size, causing him considerable dyspnea and dysphagia with suffocative attacks particularly at night. His general health has been fairly good with no symptoms referable to the gastro-intestinal cardiac, genito-urinary or nervous systems of any merit. There was no symptomatic evidence of any hypo- or hyperthy-

(Continued on Page 338)

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FOR THE MEMBER

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1. *Program Material.* Pursuant to authorization by the 1924 House of Delegates the Secretary is arranging to make program material available without cost. The following can now be secured:

A. Departmental Officers of the State Board of Health. Address Dr. C. A. Harper, State Health Officer, State Capitol, Madison, Wis.

B. Clinicians of the Wisconsin Anti-Tuberculosis Association when in vicinity. Address Clinic Dept., W. A. T. A., 558 Jefferson Street, Milwaukee.

C. Councilors and Officers of the State Society. Address the individual.

2. *Annual Statements.* Uniform annual statements can be had without cost. Address the Secretary, advising number desired.

EDITORIALS

THE PRECEPTOR SYSTEM IN MEDICAL EDUCATION FROM THE STANDPOINT OF THE STUDENT

This editorial, written by a fourth year University student, giving his impressions of the preceptorial extra-mural method of teaching adopted at the University, is, we believe, worthy of this column.—Editor's Note.

AT the twenty-sixth annual meeting of the Association of American Medical Colleges held at Chicago, Illinois, February 8, 1916, Dr. Charles R. Bardeen, Dean of the Medical School, University of Wisconsin, in his paper on the "Aims, Methods, and Results in Medical Education" has this to say: "The old apprenticeship system in medical education has some marked advantages which the present system of mass instruction lacks. Is it not possible to restore some of the advantages of the old apprenticeship system without loss of modern scientific training? Can we not utilize a large number of clinical centers for clinical teaching and a large number of progressive men as teachers instead of restricting clinical teaching to a few men connected with large hospitals adjacent to medical schools in large cities?"

Just ten years from that time the preceptor system of clinical instruction was introduced at the medical school of the University of Wisconsin. The plan consists of sending the fourth year medical class to various medical centers throughout the state for a period of three months during the last half of their senior year. A preceptor has been appointed in each medical center, and not more than two or three students are assigned to each preceptor. The preceptor may appoint as many associate preceptors as are necessary to assist him.

The plan is a wide departure from the general scheme of medical education, although a few schools are trying out similar plans and others have them in contemplation. The question is: "Will it or will it not be successful?" Only after a period of, say, five years' trial will this question be adequately answered. But in the meantime a guess may be hazarded by this one "subject of the experiment" that the answer will be in the affirmative.

It is a real privilege for small groups of students to be under the guidance and direction of men of wide experience and reputation in the private practice of medicine; men whose experience is not confined to medicine in their own center but whose influence has been felt throughout the state, not only in the medical profession from its scientific point of view but also in the medical education problems of the state and, may I not say, the nation.

The intimate contact of the student with the preceptor in a medical, as well as a social way, provides a stimulus which could be obtained in no other way. The writer has already found the preceptor plan one of the brightest spots in his undergraduate days. The preceptor is big enough and broad enough and can see far enough ahead to appreciate that he did not arrive at his present enviable position spontaneously; consequently, the student has the opportunity to come into the most intimate personal contact with his instructor, and he has the opportunity of observing the intimate personal relationship of physician and patient, which is so absolutely fundamental to sound practice and most certainly essential to the proper care of the patient.

Theodore Billroth said, fifty years ago, "A person may have acquired from books a vast amount of medical knowledge; he may even have memorized from books the technique of its application. Such a person has much knowledge of medicine, and yet with it all he is no physician. He must see and hear a Master's diagnosis, prognosis, and treatment of disease. He must witness the Master's skill in action, in order himself to become a practitioner."

A. W. W.

WHAT CONSTITUTES A GOOD CASE REPORT?

A GLANCE over the reports in our medical journals shows that there is a wide variation in the form of publication. Some reports are jerky, abbreviated and appear to be taken verbatim from the notes on the hospital histories. Others are so filled with figures of laboratory tests

that the mind fails to grasp the essential points. It is too much to expect that all men who have something to say know how to say it in language which is Stevensonian. However, it does not appear to be beyond the bounds of possibility to improve the reports of cases so as to provide an easy flowing style.

We can take a leaf from the reports of the old masters whose published case histories are so fascinating to read. Our rushing, mechanistic age requires brevity and efficiency but it should be possible to be both brief and efficient and at the same time so to frame the case report that the reader's mind is not bombarded with rows of figures and disjointed sentences.

The average case report gives this writer the impression that the author had set out to perform every test which could be applied, irrespective of whether important information could be gained or not, and then had listed them in order to show to the reader that it was possible, in the place where he worked, to have all the various laboratory tests carried out. In this connection it might be well again to call attention to the fact that some of the blood tests are difficult, a slight change in the standard solution or in the technique may give a most misleading result which, because it is from the laboratory, is often accepted even when contrary to the data obtained from the history and physical examination.

Case reports could certainly be made more interesting reading. They could be dressed up in a bit of finery and even sprayed with a dash of perfume. Unnecessary data could be deleted; negative findings, unless essential to the diagnosis, might well be left out. One might use a few more words so that the style flows along and the mind easily grasps the essential data. It is not necessary to be pedantic or prolix. Clarity of expression and readability should be the author's goal.

An author's style is the expression of his own individuality in clothing his thoughts in words. Our American authors have been accused of dressing up their good thoughts in shabby clothes. The accusation is not altogether an unjust one. Sometimes it is carelessness on the part of the author. Again it is lack of previous training in writing for publication. The former can easily be corrected, the latter may be improved by study and practice, by rewriting and by criticism of those who are capable of passing judgment upon what is good English.

L. M. W.

REMOTE RESULTS

OUR knowledge of disease has been a gradual development through many stages, among the most important of which have been:

1st. Study of autopsy material, in the dead house.

22nd. Observation of living pathology, in the operating theater.

3rd. Recording of physiological activities in the x-ray room or estimating functions in the clinical laboratory.

But despite the very valuable data given by these methods of observation, our knowledge is often incomplete, and in consequence there has been an effort to learn the inaugural symptoms, or the early stages of disease; as is done at the St. Andrews Institute for Clinical Research (left to posterity by that indefatigable laborer for rational medicine, Sir James MacKenzie), and in this country by the Periodic Health Examinations that are being deservedly popularized.

The discovery of early behavior of disease processes will, without question, be of great help in promoting health, yet there is a necessity for a corollary to this study of disease beginnings, that is, a study, equally comprehensive, of the remote results of treatment or management.

Immediate results are dramatic, conspicuous and are forcibly impressed upon one's mind, while remote results are often unknown, frequently misunderstood and therefore give rise to erroneous conclusions relative to the efficiency or inefficiency of attempt at cure.

With recorded periodic examinations before, and records as to the subsequent development of disease, and facts as to the remote or final results added to our understanding of the actual disease process itself, we shall be armed with knowledge that will justify rather definite health recommendations.

All of which remind one that the duty of the physician is to "observe, compare and record," not only during the entire course of the disease, but during the entire course of the individual's life.

—F. G. C.

THE PRESIDENT'S PAGE

Arthur W. Rogers

NURSING PROBLEMS

WHEN we circularized the county medical societies a short time ago regarding their "nursing problems," our object was not only to secure concrete information concerning your troubles in this respect, but to get the various angles of this problem as presented from various sections, and thereby get a cross section of the state at large and to secure material for your state committee to work upon. Many of the societies have appointed committees who have sent in some very valuable reports, and others have given over an entire session for the discussion of this subject, but a goodly number of societies are still to be heard from.

We are quite alive to the fact that nursing in the smaller towns and definitely rural sections presents quite a different problem from that in the metropolitan centers. The difficulties in the latter are more easily solved, because of the tendency of nurses not only to center there, but to be unwilling to accept employment elsewhere. We are more anxious to hear how nursing in the outlying districts is taken care of. Our only criticism of the reports already received is that they have in their replies adhered too closely to the questions propounded, and have not been sufficiently free in their suggestions. Please appreciate the fact that we desire to work out this problem in such a manner that the profession at large may be better served in the matter of nursing.

For some time a number of our profession have expressed great dissatisfaction with the "manner of the nurse" and her profession, so now is the time to take this matter under full consideration and get in your report. That there are reasons for dissatisfaction no one can rightfully deny, but without your reports nothing of value can be accomplished, and the problems really solved. We believe there is an amicable solution for this disaffection, and we desire your help; so let us hear from all.

We hope at an early date to set forth in the State Journal the high spots of the situation.

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ORGANIZED 1841

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SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

The Brown-Kewaunee County Medical Society held its May meeting on the 3rd of the month at six o'clock in the Northland Hotel, Green Bay. The meeting was held in conjunction with the Bar of Green Bay and the surrounding county medical societies and was well attended by physicians from Marinette, Appleton and Oshkosh. The total attendance numbered ninety-six.

Dr. Ralph Webster, professor of medical jurisprudence at the Chicago University and director of the chemical department of the Chicago Pathological Laboratory, gave a very interesting talk on "Malpractice," bringing out many important legal points. *M. H. F.*

CHIPPEWA

The members of the Chippewa County Medical Society met in monthly session on May 10th at Hotel Chippewa. Earlier in the day the physicians convened at the St. Joseph's hospital to observe patients.

Dr. J. C. Litzenberg of the Nicollet Clinic, Minneapolis, spoke on "Convulsions in Pregnancy." Dr. James Johnson, also of the clinic, spoke on "Treatment of Goiter." A motion was passed that people be warned against the "Dr. McCoy" articles in the daily papers. Dr. McCoy is not a physician and has no right in this state to use the title of a doctor. His record can be found in the April 1927 edition of Hygeia. *W. C. H.*

DANE

Prof. M. F. Guyer, University of Wisconsin, addressed the members of the Dane County Medical Society at the Park Hotel on Tuesday, May 10th. His subject was "The Basic Science Law." Mr. George Crownhart, secretary of the State Society, spoke on "Medical Legislation." A dinner and short business meeting preceded the talks. *W. J. B.*

EAU CLAIRE AND ASSOCIATED

The members of the Chippewa County Medical Society and their wives were guests of the Eau Claire and Associated Counties Medical Society at the first annual get-together and dinner-dance held on April 25th at the Hotel Eau Claire. There was dancing between courses and at the conclusion of the dinner until twelve o'clock. Cards were provided for those who did not care to dance.

Plans are being made by the members of the two medical societies for the state convention to be held at Eau Claire in September. *H. M. S.*

FOND DU LAC

Fifty-six persons attended the dinner of the Fond du Lac County Medical Society held for physicians and their wives at the Hotel Retlaw on Wednesday, May 11th. An interesting talk on "Caricatures of Medicine", illustrated by lantern slides, was given by Dr. Chauncey D. Leake, professor of medical ethics at the University of Wisconsin School of Medicine. Dr. Leake explained caricatures of the medical profession as they came up from the year 1700 to the present time. *H. R. S.*

GRANT

A meeting of the Grant County Medical Society was held in the Municipal Building at Boscobel, Tuesday, May 10th, beginning at two o'clock. The following scientific program was presented "New and Simple Methods of Chest Diagnosis" by Dr. Alton Ochsner, Madison; "Cholecystography", Dr. R. C. Blankinship; "X-Ray Therapy," Dr. J. H. Schrup, Dubuque, Iowa; "The Management of Posterior Positions of the Occiput," Dr. Carl S. Harper, Madison, and "The Relation of the Specialist to the General Practitioner," by Dr. J. H. Fowler.

The medical society had dinner with the Boscobel Kiwanis Club and was addressed by Mr. R. L. Cooley, of Milwaukee, chairman of the Under Privileged Child Committee.

The following officers were elected for the ensuing year Dr. C. S. Hayman, president; Dr. C. H. Andrew, vice president; Dr. M. B. Glasier, secretary-treasurer; Dr. J. C. Betz, delegate to the state meeting; Dr. J. H. Fowler, alternate, and Dr. E. C. Howell, censor. *M. B. G.*

JEFFERSON

The nursing problem was thoroughly discussed at a meeting of the Jefferson County Medical Society on May 17th. The Committee on Nursing of the county society was in charge of this meeting and the members listened to several interesting addresses on the subject following a six o'clock dinner. *A. C. N.*

ROCK

Sixty-five physicians attended the April meeting of the Rock County Medical Society held in the Y. M. C. A. dining room, Beloit. Physicians from Janesville, Oregon, Rockford and other surrounding towns were present.

Dr. W. H. McGuire, Janesville, president of the society, introduced Dr. Benjamin Fosse, of the Beloit Clinic, who gave a paper on "Fundamentals of Thyroid Diseases." Dr. H. E. Kasten, also of the Beloit Clinic, presented an address on "Significance of Urinary Findings."

Dr. A. W. Christiansen, Rockford, Ill., president of the Winnebago County Medical Society, spoke and invited Rock County physicians to attend a coming meeting of his organization in Rockford. Dr. James M. Beveridge, Oregon, president of the Ogle County Society, also issued an invitation.

A "fake" radio stunt, arranged by Dr. C. F. N. Schram, brought in the names of local physicians cleverly and numbers were given as though actually broadcast from well known stations. *H. E. K.*

WASHINGTON-OZAUKEE

The members of the Washington-Ozaukee County Medical Society met at Hilgren Spring Park, Cedarburg, on May 19th. A chicken dinner preceded the following program "The Relation of the State of Wisconsin General Hospital to the State," Dr. R. C. Buerki, Supt. "Infant Feeding, as it Applies to the General Practitioner," Dr. J. E. Gonce; "The Diagnosis of Skin Diseases, as it Applies to the General Practitioner," Dr. R. L. McIntosh and

"Diets, as it Affects the General Practitioner," by Dr. E. L. Sevringhaus.

The splendid program was furnished the society by the University Extension Division, Madison. *A. H. H.*

WAUPACA

Dr. C. J. Combs, Oshkosh, gave a very interesting talk on "Fractures," illustrated with lantern slides, at a meeting of the Waupaca County Medical Society, held at the Library Hall, New London, Thursday evening, April 28th. Dr. J. W. Monstad, presented an instructive paper on "Diabetis." Following a lively discussion by the physicians, the meeting adjourned. *A. M. C.*

NINTH COUNCILOR DISTRICT

The annual meeting of the Ninth Councilor District was held at River Pines Sanatorium, Stevens Point, on the afternoon and evening of May 11th. Beginning at four o'clock the following program had been arranged: Exhibition of Cases of Tuberculosis by Dr. J. W. Coon, River Pines Sanatorium "The State Medical Society and Its Functions" by Dr. Arthur W. Rogers, President of the State Society.

The visitors were guests of Dr. J. W. Coon of River Pines at dinner after which the meeting was continued. A "Symposium on Tonsillectomy" was given by Drs. L. M. Freeman, Wausau, and L. M. Willard, Wausau. Discussion on this subject was opened by Drs. William Hipke, W. G. Merrill and H. H. Christofferson. Drs. W. G. Sexton and J. B. Vedder presented a paper on "Glimpses of Medicine in Europe," and Dr. Arthur W. Rogers spoke on "Diagnosis and Management of Some of the Commoner Forms of Insanity."

Dr. Halfdan Raasock, Nelsonville, was elected president of the Ninth Councilor District Society and Dr. Joseph F. Smith, Wausau, was re-elected secretary-treasurer. *J. F. S.*

SECTION ON RADIOLOGY

The Radiological section of the State Society held a most successful meeting at La Crosse on Saturday, May 14th. The morning was spent at St. Francis Hospital where cases and x-ray films were presented by Drs. Evans, Evans & McLoone. Dr. Edward Evans then held a clinic on the removal of kidney stones, using the bedside x-ray in the operating room to insure the removal of all of the stones. After a tour of inspection through the hospital, Dr. Edward Evans was host at a delightful luncheon, served by the sisters at the hospital.

The business meeting as well as the afternoon and evening scientific program was held at the Lutheran Hospital. The section unanimously adopted the following resolution to show their appreciation of the very efficient work done by our Secretary relative to the recent proposed legislation pertaining to radiology:

WHEREAS, During the past session of the legislature of Wisconsin, many bills were introduced affecting the health interests of the citizens of the state and the status of the Wisconsin physicians, and

WHEREAS, Mr. J. G. Crownhart, the Secretary of the State Medical Society, worked with untiring zeal in behalf of both community health and the medical fraternity's best interests, and

WHEREAS, Mr. J. G. Crownhart showed exceptional ability and tact in the placing of pertinent facts before the various interested legislative committees, so that the legislature might have the benefit of clear, concise and exact information on the medical problems that presented themselves to them.

BE IT RESOLVED, That the radiological section of the Wisconsin Medical Society at this, its regular semi-annual meeting, express its appreciation of Mr. J. G. Crownhart's labors in behalf of legislation beneficial to both physicians and community health, and that a vote of thanks be and is hereby tendered to Mr. J. G. Crownhart and

BE IT FURTHER RESOLVED, That this resolution be spread and become a part of the regular minutes of this Society, and that copies of this resolution be forwarded to Mr. J. G. Crownhart and to the President of the Wisconsin State Medical Society.

(Signed) H. B. PODLASKY, M.D., Committee.

The section also pledged their willingness to cooperate with the Radiological Society of North America in establishing a suitable memorial for the late Drs. Carman and Sandborn, long prominent in radiological work.

The afternoon program consisted of papers by: Mr. R. T. Morrison, of the Eastman Kodak Company, on developments in the manufacture of films and the elimination of "static" from screens and films; a symposium on Kidney Pathology by Drs. R. P. Potter, Marshfield; Alfred Gunderson, La Crosse; F. J. Hodges, Madison; Edward Evans, La Crosse; "Gastro-Intestinal Conditions from the Clinical View Point" by Dr. J. E. McLoone, La Crosse; "Duodenal Stasis," by Dr. J. A. Evans, La Crosse.

Dinner was served by the nurses of the Lutheran Hospital. After the dinner Dr. Edward Evans, councilor of the Seventh District Society, gave a short address of welcome to the section and then introduced the Hon. J. J. Verchota, mayor of La Crosse, who on behalf of the city welcomed the section.

Continuing the program, Dr. Gentz Perry, Milwaukee, chairman of the section, gave a short paper on "Ethics." The principal address of the meeting was given by Dr. Byrl R. Kirklin, of the Mayo Clinic, on "Certain Practical Phases of Cholecystography by the Oral Method."—H. C.

MILWAUKEE ACADEMY

Dr. F. Gregory Connell, of Oshkosh, addressed the members of the Milwaukee Academy of Medicine, on "Repair of the Internal Ring in Oblique Inguinal Hernia" on Tuesday evening, May 10th. Other papers were presented by Dr. J. F. Schneider, Oshkosh, on "Ureteral Stricture," illustrated with lantern slides, and by Dr. J. E. Gonce, Madison, and Dr. K. E. Kassowitz, Milwaukee, on "The Action of Ultraviolet Radiation on the Bactericidal Property of the Blood."

At the meeting of the Academy on May 24th Dr. Henry F. Helmholz, of the Mayo Clinic, Rochester, Minn., was the speaker of the evening. "Disturbances of the Thyroid Gland in Infancy and Childhood" was his subject. Dr. J. L. Yates, Milwaukee, spoke on "The Causes and Significance of Distorted Sedimentation Rates."

Gifts of books have been received from Drs. Kastner, Chapman, Grove, G. V. I. Brown, Henes, Black and "I. J." Dr. Washburn has given his general library of 370 volumes. The Wisconsin Anti-Tuberculosis Association presented the Academy with a fine collection of books, reprints and other literature, together with a classification of this material.—D. E. W. W.

MILWAUKEE OTO-OPHTHALMIC

The regular monthly meeting of the Milwaukee Oto-Ophthalmic Society was held on Tuesday, May 17th, at the University Club, preceded by a six-thirty dinner.

"Self-Induction of Colors Over the Retina" was the subject of an address by P. F. Swindle, Ph.D., professor of Physiology, Marquette University School of Medicine. Dr. J. A. Bach spoke on "Ophthalmological Impressions from a Recent Visit to the Orient." This was the last meeting of the society before the summer recess.—E. R. R.

WISCONSIN ANTI-TUBERCULOSIS

Under the auspices of the Wisconsin Anti-Tuberculosis Association the following program was presented on May 28th: Clinic on "Tuberculosis in Children" at the Milwaukee Children's Hospital beginning at 2 o'clock. "Tuberculosis of Bone and Joint in Children" by Dr. F. J. Gaenslen, Milwaukee; "The Normal Chest in Children" by Dr. J. A. Meyers, University of Minnesota; Demonstration on "The Diagnosis of Tuberculosis in Children" by Dr. F. M. Pottenger, Monrovia, Calif.

The afternoon session was held at the Milwaukee Academy of Medicine where Dr. J. A. Meyers presented a paper on "The Normal Chest in Adults;" Dr. F. M. Pottenger on "The Diagnosis of Suspected and Early Clinical Tuberculosis;" Dr. David A. Stewart, Manitoba Sanatorium, Canada, on "Septic Infection of the Bronchi and Lungs."—O. L.

NEWS ITEMS AND PERSONALS

The Madison Board of Health has sent Dr. A. M. Carr, city health officer, and five nurses for relief work in the flood areas of the Mississippi valley. This offer from the board of health was accepted by telegram from Herbert Hoover several weeks ago. Dr. Carr and the five nurses will give their services for one month, the time to be designated by those in charge of the general relief program.

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Laugh at physical injuries but treat them seriously, Dr. J. C. Elsom of the University of Wisconsin, told his listeners recently in a first aid address over the University station WHA. "The cardinal principle in all first aid treatment is to keep cool yourself and by all means encourage the patient as much as possible under the circumstances."

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Dr. J. C. Wright, Antigo, has again returned to Wisconsin after a four months' vacation in California, Oregon and Washington. The doctor attended several medical meetings and visited a number of hospitals.

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An address on the observance of health day was given before an audience of 800 at West Bend recently by Dr. F. F. Bowman of the State Board of Health, Madison.

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Dr. E. R. Schmidt, chief surgeon at the Wisconsin General Hospital, Madison, has returned to his home from Berlin, Germany, where he attended the European Surgical Congress. Dr. Schmidt also visited in other European cities during his brief stay abroad.

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The Commission Council of Oshkosh has appointed Dr. E. J. Campbell as city health commissioner and city physician. Dr. Campbell fills the vacancy created by the death of Dr. A. H. Broche as health commissioner and replaces Dr. A. G. Koehler, former city physician. The doctor holds office for a term of one year, his tenure expiring May 1, 1928.

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Dr. and Mrs. C. E. Smith have returned to Beloit after an extended trip through the south and west, begun after Dr. Smith severed his connections with the Beloit Clinic several months ago. They will reside in Beloit temporarily but may return to California later to live.

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Dr. Eben J. Carey, director of anatomy and acting dean of the Marquette University School of Medicine, addressed recently the Englewood branch of the Chicago Medical Society on "Normal Structure and Function and Deformities of the Human Spine."

—△—

The board of health for the city of Baraboo has been organized with Dr. F. E. Tryon as health officer.

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Dr. and Mrs. A. T. Gregory, Mauston, who spent the past five months in Hot Springs and Little Rock, Ark., arrived home several weeks ago. They visited at St. Louis, Chicago, and Milwaukee on their way home, and reported that the devastation from the flood waters is terrible and is beyond description.

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Dr. W. C. Nason, Ripon, has received his commission from the state Adjutant General Ralph M. Immel, as captain in the medical corps, Wisconsin National Guard, and is assigned to the medical detachment of the 127th Infantry stationed in Ripon. Dr. Nason succeeds Dr. H. A. Schulz whose resignation followed his leaving Ripon a number of weeks ago to establish his practice at Fremont.

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"Body Building in Children" was the subject of the address by Dr. Charles R. Bardeen, professor of anatomy and dean of the medical school of the University of Wisconsin, before the Second Conference on Research in Child Development, held at Washington, D. C., during the first week in May.

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Twenty-five local physicians and six guests, attended the monthly meeting of Mercy Hospital staff, Janesville, held Thursday evening, May 5th, in the hospital dining room. Dr. Wayne A. Munn, president of the staff, opened the meeting with a brief history of the hospital in which he traced the development of the institution.

Informal discussion followed in which the relation of the hospital to the city of Janesville was emphasized and

means suggested by which the staff, the board and the nuns may work together for the good of the hospital. The program was in observance of National Hospital day, Thursday, May 12th.

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The Neenah Board of Health organized and elected officers at a recent meeting in the city hall. Dr. I. E. Ozanne, city physician, was re-elected health commissioner of the city.

—△—

Dr. Harold Helm, Beloit Clinic staff physician, has returned recently from six weeks' study at Washington University in St. Louis. He pursued a post graduate course in pediatrics at the institution.

—△—

Dr. C. W. Henney, Portage, and Dr. A. A. Hoyer, Beaver Dam, sailed from New York on the "Celtic" May 21st. The doctors attended the American Medical Association meeting at Washington, D. C., the week previous to their departure. They will visit the clinics of London, Liverpool, Glasgow, Edinburgh, Oslo, Hamburg, Stockholm, Munich, Heidelberg, Bonn, Frankfort and Cologne.

The medical tour, of which the two physicians are members, will end at Paris on July 9th, after which it is their intention to go to Vienna for a six weeks' course in the treatment of gastric and intestinal diseases, returning home by the way of Rome about September 10th.

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Misericordia Hospital, located at 2224 Juneau Avenue, Milwaukee, was formally opened as a general hospital on March 1, 1927. A general staff has been organized and the hospital is now in position to handle both medical and surgical cases. The newly organized staff enjoyed its first dinner meeting during April at which time Dr. John P. Koehler, Milwaukee health commissioner, spoke on "Staff and Hospital Cooperation."

The following members were elected by the staff for the ensuing year: Chief of Staff, Dr. L. J. Foley; Vice President, Dr. L. J. Hargarten; Secretary, Dr. P. J. Merten, and Treasurer, Dr. W. J. Murphy. The staff meetings are to be held on the second Monday of each month.

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Drs. F. T. Clark and L. L. Taylor were recently appointed city physicians by the common council of Waupun.

—△—

The Nutrition Institute to be given under the direction of the State Board of Health will be held in Milwaukee, June 20th to July 2nd. Dr. Wm. R. P. Emerson and his assistant, Miss Mabel Skilton of Boston, will conduct the institute. In addition to the Nutrition course, other lectures and demonstrations of interest will be given and round-table discussions will be arranged for.

—△—

The Child Welfare Special of the State Board of Health has been repaired and is ready for its sixth season in the rural districts. Starting in Manitowoc County, it will visit Kewaunee and Door before going into the northern and northwestern part of the state. Dr. Sylvia Stuessy, Madison, again will be the examining physician.

—△—

At the annual meeting of the St. Mary's Hospital staff, Madison, the following officers were re-elected Dr. Joseph Dean, president; Dr. H. E. Purcell, vice president; Dr. R. C. Aylward, secretary-treasurer. Dr. F. B. Taylor was also elected to staff membership.

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A special exhibit has been arranged during the month of May in the exhibit case in the Wisconsin General Hospital, of important facsimiles of rare medical books. This has been done in order to call attention to the publication by the Wisconsin Historical Society of a facsimile edition of the Pharmacopoeia Augustana. This pharmacopoeia was first published in 1564 in Augsburg, Germany, and only two copies are known to be in existence. It was among the first and most influential of pharmacopoeias and served as a model for the later development of these official guides.

The facsimile reproduction was arranged through the combined efforts of Professor Kremers of the Pharmacy Department, Dr. Schafer of the Wisconsin Historical Society, and Dr. Schneider of Milwaukee. It was published as Volume I of the Hollister Pharmaceutical Library. Dr. Schneider of Milwaukee, an alumnus of the University of Wurzburg, made it possible for the reproductions to be made by presenting his alma mater with a photostatic apparatus, so that an exact copy could be placed at the disposal of the editors.

As the exhibit indicates, this publication of the Wisconsin Historical Society is among the first facsimile reproductions of important medical works to be made in America.

DEATHS

Dr. Julius C. Sommers, Madison, died at a local hospital on May 5th after a long illness. Although Dr. Sommers had been ill for about a year, he had been a patient at the hospital only recently. Dr. Sommers was born in Blooming Grove on Aug. 5, 1869. He attended the Madison public schools and in 1897 entered the University of Illinois College of Medicine, Chicago, from which he was graduated in 1901. The doctor opened his Madison office for the practice of medicine and surgery the same year at 14 E. Mifflin Street, which offices he maintained up to the time of his death.

Dr. Sommers was county physician for twelve years and acted in the capacity of city health officer for several years. He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his wife, one sister and one brother.

Dr. F. C. Moulding, Watertown, died on May 11th at St. Mary's Hospital. Dr. Moulding had been in failing health for a long period of time and entered the hospital about six weeks previous to his death. He was born in Elburn, Ill., in 1854, attended Rush Medical College at Chicago and in 1876 received his degree from the School of Medicine of the University of Michigan, Ann Arbor.

Dr. Moulding served throughout the Spanish-American war, being a member of the Second Wisconsin National Guard. He also served both the Chicago & North Western and the Chicago, Milwaukee & St. Paul railroads as their local surgeon and later, when he was unable to devote his time fully to those duties, he was made consulting surgeon. Surviving him are his wife and one sister.

Dr. Paul J. Kappes, Milwaukee, died at his home on Sunday, April 24th. Dr. Kappes was born in Germany in the year 1862 and was graduated from the University of Bonn in 1888. He was licensed in Wisconsin in 1900 and has practiced in Milwaukee since that time. The deceased is survived by his wife and two daughters.

Dr. Warner B. Strong, Milwaukee, died at the West Side Hospital, Chicago, on May 2nd. Dr. Strong was born in 1861 at Milwaukee and was graduated from the General Medical College, Chicago, in 1902. He practiced for a time in Waukesha later removing to St. Martins. About fifteen years ago he established an office in Milwaukee. Surviving him are his wife and a brother.

CORRESPONDENCE

WISCONSIN REUNION

May 16, 1927

Mr. J. G. Crownhart,
153 E. Wells St.,
Milwaukee, Wisconsin.

Dear Mr. Crownhart:

Please make the following announcement in the June issue of the Wisconsin Medical Journal:

The first class to graduate in Medicine from the University of Wisconsin will receive their degrees on Monday, June 20. The faculty of the Medical School is anxious to signalize this event by having a reunion of all those interested in the development of the University of Wisconsin Medical School. A cordial invitation is therefore extended to all those who have had any training in Medicine at the University of Wisconsin, or who may be interested in any way in the medical work at the University, to come to Madison for this occasion. A luncheon will be served in the Wisconsin General Hospital at noon and will be followed by a brief address by Dr. Dean Lewis, Professor of Surgery, Johns Hopkins University. The laboratories and clinics of the Medical School will be opened for inspection on this day, and it is hoped that the visitors will avail themselves of the opportunity of renewing personal contacts with the Medical School staff. A special exhibit will be made of outstanding contributions to Medicine made by Wisconsin men.

Yours very truly,
CHAUNCEY D. LEAKE.

REPORTS WANTED

Wisconsin Medical Journal,
Milwaukee, Wis.

Dear Mr. Crownhart,

The library of the Wisconsin Anti-Tuberculosis Association lacks only seven of the thirty reports of the State Board of Health, thanks to the devoted perseverance of Mrs. U. O. B. Wingate, wife of the doctor who from 1893 to 1902 was secretary of the State Board. She has exercised unusual resourcefulness in following through all clues as to the possible whereabouts of old reports, and has been able to add to the Association's file volumes covering the work of the Board for thirteen years.

Perhaps some readers of the Journal may have suggestions as to where the few remaining reports might be obtained and would be kind enough to pass on to the W. A. T. A. this information. The following are the numbers still missing:

No. 10 — 1886	No. 14 — 1891-92
No. 12 — 1888	No. 15 — 1893-94
No. 13 — 1889-90	No. 17 — 1897-98

No. 18 — 1899-1900.

Aimee Weinstock,
558 Jefferson St.
Milwaukee.

THE X-RAY BILL

Edward Joseph Campbell, M. D.
Oshkosh, Wisconsin.

The Wisconsin Medical Journal,
Mr. J. G. Crownhart, Managing Editor,
Milwaukee, Wisconsin.

Dear Mr. Crownhart:

The Wisconsin Medical Journal, in the issue of April 1927, presents a lengthy discussion of the recent Assembly Bill 151A and the substitute amendment thereto. In discussing this bill the Journal has fully presented the attitude and the activities of the State Medical Society. In fairness to your readers I believe you should give equal prominence to a discussion of the bill from the standpoint of a proponent of the bill, since usually there are two sides to most discussions and if your journalistic policy is tempered at all with a sense of fairness and justice you will welcome such discussion in your Journal.

Mindful of the fact that much has been said and done by both sides in this matter, I wish to present the reasons for the introduction of Assembly Bill 151A and the substitute amendment thereto. The bill was presented only for the protection of suffering humanity from the incompetent radiologist, both within the medical profession and without it as well. The proponents of this bill, contrary to all that may have been said and done, are respected citizens of this state and, although not members of the State Medical Society, I believe that fact does not detract from their respectability, nor their duty as good citizens to protect the public from any incompetent practitioner of medicine, be he licensed or otherwise. Donald B. Campbell, x-ray technician to the Oshkosh Clinic, is the son of W. J. Campbell, recently active in the reorganization of the Republican Party in this state and a prominent lumberman of the state. John Thompson, Jr. is the son of J. C. Thompson, ex-president of the Wisconsin Bar Association and the head of one of the most prominent law firms in the state. The writer has practiced medicine in this state for over fifteen years, his father has practiced for over forty years, and in the March 24, 1923 issue of the J.A.M.A. the writer was highly commended by that publication for driving from this state one of the most notorious quacks that ever infested this locality. The writer has never countenanced any quack, charlatan or faker in the medical or allied professions. As a boy the writer carried his father's grip as he made his calls; today the writer while carrying his own grip carries with him the inspirations, memories and the traditions of his time honored father and of a time honored profession as well.

The science of the Roentgen ray is not very old, neither is the legalized practice of medicine. The practice of radiology today occupies the same position as the practice of medicine did before it was regulated by law. It is not many years ago that the only requisite necessary for the practice of medicine was the painting of a sign, the purchase of a few instruments, the putting on of a professional air and the nerve to go to it. The practice of radiology today is exactly on the same level. The purchase of electrical equipment, the assumption of competence and putting on the appearance is all that is necessary to become a practitioner. The state requires the practitioner of medicine to be examined in all branches except radiology and if it is necessary for the practitioner to show his competence in prescribing and administering drugs why should he not be required to show his competence in the practice of radiology. Permit me to quote from your issue of March 1927. The excerpt is from the address delivered at your last state meeting by Dr. Eugene Smith (Wis. State Med. Jour. page 141.)

"Front, assurance, elaborate equipment, without years of study, thought and a broad foundation of general premedical science, mean lost opportunity to help, betrayal of confidence and deserved defeat for the radiologist * * * the x-ray has been accepted as a useful part of our professional equipment, but because this art is so young, many of the men who are specalizing in it, were prepared for general practice only."

The Journal American Medical Association reprint in your issue of December, 1926, page 634, vigorously condemns the x-ray practitioner that practices only upon having been seduced by the glitter and glamor of x-ray equipment and x-ray sales agencies. Infecting the profession with the parasite of commercialism the manufacturers' agents perpetrate a fraud upon suffering humanity and make a faker of the physician. The same reprint condemns as "make shift" the courses given by our medical schools and the mere awakening of the American Medical Association to the abuses now prevailing is condemnation sufficient in itself. Our own state regulates the practice of medicine, the societies approve of such regulation, but at the same time they allow the x-ray practitioner to violate every basic principle of regulation. His competence is determined by his susceptibility to the siren song and the captivating dance of an x-ray sales agency or by the amount of money he possesses and the spirit of commercialism that controls his destiny.

Today we have with us two classes of x-ray practitioners, the medical radiologist and the none-medical radiologist. Both are recognized and have been created by the medical profession. They are accepted by the societies and are given recognition by the journals. The advertising columns of the journals traffic with radiologists and x-ray technicians. The non-medical technician is a creature born of the medical profession, he is nursed and sustained by that profession. I ask you sir, what state board passed upon the competence of any x-ray practitioner in this state? If it is a fundamental principle of medical regulation that the administering of drugs requires the safe guard of competence does not the administration of x-ray dosage demand the same safe guard of competence? The present practice of radiology by any person so engaged is in direct violation of the very basic principles of regulation. The competence of the x-ray practitioner has been questioned at your State Society meetings and has been published in your journal.

The main point in the discussion of the x-ray problem has not been touched upon in your recent discussion. That point is the legal standing of the non-medical practitioner in a court of justice. The employment of a technician or of any person that serves as a technician, seemed to imply the relationship of master and servant, but the Supreme Court of Arkansas, as reported in the J.A.M.A. of January 9, 1921, creates a grave doubt as to whether that relation exists. That court has decided that the physician is not liable for the negligent acts of his technician and declares that the technician is responsible for his own negligence. If the non-medical practitioner is not legally recognized as a practitioner of medicine and cannot secure financial responsibility for his acts, a person injured by x-ray apparatus would have no recompensation for his injuries. To employ such a person, without giving him a chance to secure financial responsibility, is to betray the trust that suffering humanity places in the physician and which he has a right to demand from the physician. If because economic conditions and professional jealousies the cost of x-ray equipment or lack of time for the performance of the details of x-ray practice creates the x-ray technician, it is the solemn duty of the physician to place his patient in the hands of a person thoroughly competent and financially responsible for his acts. If the technician cannot be examined as to his competence and be given the opportunity to make himself financially responsible, the medical profession should not sustain the non-medical practitioner and if they do sustain him they should make him competent and responsible.

As a proponent of the bill, the writer has endeavored to make a plain statement of his position. We should eradicate the businessman from all branches of the medical profession; let us keep it a profession. The proponents of Assembly Bill 151A and the Substitute Amendment thereto, believe that the fundamental principles of medical regulation demands that all practitioners of medical sciences should be declared competent by examination before they are allowed to practice at all. The protection of suffering humanity demands competence and responsibility. Present conditions make that demand imperative.

Very truly yours,

Edward Joseph Campbell, M.D.,
Oshkosh, Wisconsin.

POST GRADUATE COURSES

MILWAUKEE COUNTY DISPENSARY

Wauwatosa, Wis., May 4, 1927.

Mr. J. G. Crownhart,
153 E. Wells St.,
Milwaukee, Wisconsin.

My dear Mr. Crownhart:

I am enclosing herewith schedule of post graduate courses to be given during the month of August.

Will you kindly publish this in the Wisconsin Medical Journal whenever you see fit?

Very truly yours,
L. M. Warfield, M.D.
Clinical Director.

LMW/MS

SCHEDULE POST GRADUATE COURSES
Milwaukee County Dispensary.
5th St. and Wisconsin Avenue, Milwaukee.

During the month of August, members of the staff of the Milwaukee County Dispensary will give two series of clinics with patients at the hours listed below. Only a limited number of phyisicians can be accommodated owing to lack of large space. Those desiring to take the course should make application to the Dispensary before July 25th. There will be no charge for these courses.

First Course August 1st to 13th inclusive.
Second Course August 15th to 27th inclusive.

MONDAY—
9 to 10—Neurology—Dr. H. W. Powers.
10 to 11—Pediatrics—Dr. H. O. McMahon.
11 to 12—Medicine—(Tuberculosis)—Dr. L. L. Allen.
2:30 to 5—Prenatal and Obstetrics—Dr. N. E. McBeath.

TUESDAY—
9 to 10—X-Ray—Dr. H. C. Dallwig.
10 to 12—Medicine (Heart)—Dr. L. M. Warfield.
7:30—Syphilis—Dr. A. J. Hood.

WEDNESDAY—
9 to 10—Neurology—Dr. H. W. Powers.
10 to 11—Pediatrics—Dr. Bertha Haessler.
11 to 12—Medicine (Diabetes)—Dr. F. D. Murphy.

THURSDAY—
9 to 10—X-Ray—Dr. H. C. Dallwig.
10 to 12—Medicine—Dr. C. H. Stoddard.
2:30 to 5—Prenatal and Obstetrics—Dr. N. E. McBeath.

FRIDAY—
9 to 10—Neurology—Dr. H. W. Powers.
10 to 11—Pediatrics—Dr. Bertha Haessler.
11 to 12—Medicine—Dr. F. A. Thompson.

SATURDAY—
9 to 10—X-Ray—Dr. H. C. Dallwig.
10 to 12—Medicine—Dr. L. M. Warfield.

UNIVERSITY PRECEPTORSHIPS

ASHLAND
Ashland General Hospital
John M. Dodd, Preceptor in Charge

ASSOCIATE PRECEPTORS

Adellon Devilla Andrus
Adellon P. Andrus
Herbert Clarence Kimberlin
Clyde Jeffrey Smiles

EAU CLAIRE
Luther and Sacred Heart Hospitals
H. Christian U. Midelfart, Preceptor in Charge.

ASSOCIATE PRECEPTORS

Fin Gerhard Anderson
Clarence Henry Falstad
Gjermund Hoyme
Hartwick Martinus Stang
Iver Stoland

LA CROSSE
Lutheran Hospital
Adolf Gundersen, Preceptor in Charge.

ASSOCIATE PRECEPTORS

Edward Samuel Carlsson
Paul C. Gatterdam
Alf Helge Gunderson
Martin Sivertson
Nels Werner

LA CROSSE
St. Francis Hospital
Edward Evans, Preceptor in Charge

ASSOCIATE PRECEPTORS

William Edward Bannen
John Adolph Bigler
James Ambrose Evans
Matthew Aloysius McGarty
Archibald Ambrose Skemp
Dean Stanley Smith
Eugene Herbert Townsend
Herman E. Wolf

MARSHFIELD
St. Joseph's Hospital
Karl W. Doege, Preceptor in Charge

ASSOCIATE PRECEPTORS

Lyman A. Copps
Karl Herman Doege
William Hipke
Victor Alwyn Mason
Hansford H. Milbee
Roy Pilling Potter
Samuel George Schwarz
Walter Gresham Sexton
James Blaine Vedder
Harry A. Vedder

OSHKOSH
St. Mary's and Mercy Hospitals
Frank Gregory Connell, Preceptor in Charge

ASSOCIATE PRECEPTORS

Neil Andrews, Jr.
Edwin Forrest Bickel
Burton Clark, Jr.
Clarendon James Combs
John M. Hogan
John Ferdinand Schneider
Thaddeus Dewey Smith

WAUSAU
St. Mary's Hospital
Joseph Franklin Smith, Preceptor in Charge

ASSOCIATE PRECEPTORS

Verne Everett Eastman
Seth M. B. Smith

WAUSAU
Wausau Memorial Hospital
Merritt La Count Jones, Preceptor in Charge

ASSOCIATE PRECEPTORS

Roland F. Fisher
Joseph Mervin Freeman
Forrest Henry Frey
David T. Jones
Richard W. Jones

SOCIETY RECORDS

NEW MEMBERS

Monstad, J. W., New London.
Creasy, L. E., Monroe.
Carey, E. J., 200 9th St., Milwaukee.
Kelly, W. J., 2402 Galena St., Milwaukee.
Kusterman, A. F., Wauwatosa.
Ladas, H. E., 530 Wisconsin Ave., Milwaukee.
McEachern, J. M., Third and Garfield Ave., Milwaukee.
McIntire, A. M., 141 E. Wisconsin Ave., Milwaukee.
Madison, F. W., 141 E. Wisconsin Ave., Milwaukee.
Provost, B. W., 575 Layton Blvd., Milwaukee.
Wenzel, E. F., 1625 North Ave., Milwaukee.
Hickey, R. E., 85 E. Wells St., Milwaukee.
Forsbeck, F. A., State House, Boston, Mass.

CHANGES IN ADDRESS

Covey, Clyde B., Palo Alto, Calif., to U. S. Veterans' Home, Ft. Snelling, Minn.
Miller, W. J., La Valle, to 1555 Adams St., Madison.

Figures revealed from the State Board of Control's audit show that Wisconsin spent $250,379.68 in Blind Pensions in 1926. Of this amount the state appropriated $50,000, the counties expending $200,379.68.

There were 1,038 pensions granted to 624 males and to 414 females. The total blind population of the state is 2,397, nearly 50% of whom were receiving pensions. The marital state of the pensioners showed that 363 were married, 367 single, 243 widowed, 23 separated, 20 divorced and 22 not classified. It was interesting to note 22 were over 90 years of age, 3 of whom were 100 years old; that 132 were between 80 and 90 years; 229 between 70 and 80; 214 between 60 and 70 years; 131 were between 50 and 60 years, making a total of 728 or 70% over the age of 50. 124 were found to be between 40 and 50 years, 94 between age of 30 and 40, 70 were between 18 and 30 years, and 22 were not classified.

* * *

The state has outgrown the practice of planting tiny fish in its propagation efforts and while the fish now planted in Badger streams and lakes are of fingerling size, the future policy of the state will be to restock waters with fish a year old, or big enough to be caught at the time they are freed for the fishermen, Brayton O. Webster, Wisconsin director of fisheries, declared before the legislative finance committee.

Mr. Webster declared that Wisconsin is now about five years ahead of the fish propagation program of Michigan. In the latter state, he said, the practice is still being followed of distribution of fish fry with the resulting high mortality of fish plantings.

In the next five years, Mr. Webster declared, the state will be planting fish of yearling size, or more, big enough to be permitted to be caught. These fish under the plan he outlined would be placed in the various waters of the state after the close of the fishing season so that the fish would have an opportunity to become acclimated before the fishing season opened again. Fish in hatcheries are fed on liver and leaving them have a natural run before the opening of the fish season would also give them enough time to feed naturally and lose any foreign taste they may have acquired in captivity.

* * *

Wisconsin railroads have reported 50 crossing accidents during the first quarter of this year, the railroad commission has announced. These accidents resulted in one death and serious injury to 31 people. Forty-six of these accidents involved automobiles. The commission announced that it had approved plans for the addition of eight new auto flagging stations. Besides the crossing accidents the railroads reported 125 other accidents resulting in 16 deaths and injuries to 77 others. This list included the killing of seven trespassers and the injury of five.

* * *

Taxes totalling $6,613,639 have been levied on the 32 railroads of the state this year, an increase of $127,341 over the amount levied last year, the state tax commission has announced. The figures presented by the tax commission show that the Badger railroads were valued at $347,-202,000 in 1926 while the valuation this year has been placed at $350,596,000. The total railroad tax last year amounted to $6,485,288.94.

* * *

The State Board of Health rules that in case of contagious disease in apartment building or institution placard may be placed on room entrance. Health officer in one community may quarantine person from another community if notified by health officer of other place that a positive culture has been obtained.

* * *

Agents who sell the Magnecoil system of treatment under the plans and practices of that system are violating Wisconsin statutes regulating the practice of the healing art, Attorney General John Reynolds has informed Raymond E. Evrard, district attorney of Brown county. Magnecoil is advertised as a "thermo-electro-magnetic blanket containing 1,200 feet of Magnecoils." These are said to arouse molecular activity and to aid in treatment of chronic diseases. The agents, through the administration of the Magnecoil system, are regarded as regulators of the treatment and not salesmen, Reynolds found.

* * *

Drugs cannot be sold in Madison except by a registered pharmacist, Superior Judge S. B. Schein ruled in holding

that the Central Stores Company be bound over to circuit court for trial on a charge of selling iodine and aromatic spirits of ammonia without the services of such an expert.

Judge Schein held, however, that drugs listed in the U. S. pharmacopoeia could not be sold without the services of a registered pharmacist, or in villages with populations of less than 500 persons, without the services of an assistant registered pharmacist.

* * *

The only bill in the Wisconsin legislature calling for censorship of moving pictures died in the assembly with no one sufficiently interested in it to mourn its fate or ask a roll call. The measure, sponsored by Assemblyman Theodore Swanson of Ellsworth, would have imposed regulations by which a chief of police could become the official movie censor of his domain. Before any film could be shown a police appointed representative would be required to view the picture at a private showing and pass judgment as to whether the picture was immoral, unmoral, or otherwise. He could forbid its showing and his word would have been final.

* * *

For the year 1926 Wisconsin spent $67,926.74 under the Old Age Pension Law. This law was in operation in five counties, Brown, La Crosse, Outagamie, Sawyer, and Wood. Brown county has, however, revoked the pensioning system, having done so in November, 1926, leaving four counties now operating under the law. The State Board of Control's audit reveals that each county was reimbursed under the terms of the law, one-third of the amount they expended from the State's annual appropriation of $200,000. The counties actually expended $45,-284.49 and the state $22,642.25.

The figures further disclosed show that 352 pensions were granted to 217 males and 135 females. The average pension amounted to $22.80 per month or 75 cents a day. Pensions ranged as low as 17 cents a day to $1.00, the maximum allowed by the law. The marital status of the pensioners showed that 194 were widowed, 110 married, 33 single, 9 divorced, and 6 separated. It was interesting to note that 109 were born in Wisconsin, 125 in other states, and that 118 were foreign born. The applications showed that 76 pensioners owned their own homes and that 13 owned other real estate. Of the 352 granted pensions, 116 were living with their children, 79 were living alone, 74 with their wives and 14 with their husbands, 42 were living with friends, and 27 with relatives.

* * *

The Wisconsin legislature has enacted a law creating a forest and game preserve in Oneida county.

Another bill enacted into law provides that state institutions for the care of feeble-minded shall be known hereafter as "colonies."

* * *

That manufacturers of Swiss cheese are permitted to use a lower content of milk butter fat for the making of full cream cheese was held by the Supreme Court in a recent decision involving the Langlade Creamery Company. Originally an action was begun against this company challenging the validity of the so-called skim milk law passed by the legislature two years ago. The Supreme Court, however, found that it was a special statute relating to the manufacture of Swiss cheese holding a low content of butter fat.

* * *

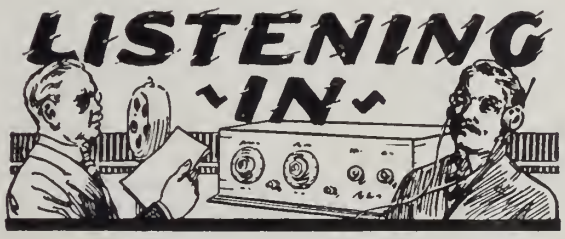
A deputy state health officer reported small pox prevalent in Ladysmith with 13 cases reported. Quarantine laws are being strictly enforced, and vaccination is being urged for all persons.

* * *

The Senate has killed the Titus bill which would provide for the repeal of the Blaine tax law enacted two years ago. The Titus bill would have restored the personal property tax to the state income tax law, and would have shifted a part of the burden now borne by incomes to real estate. The senate defeated the measure.

By a vote of 51 to 21 the assembly non-concurred in the Goodland bill designed to lower the school age for those required to attend vocational schools.

Announcement was made late in May by the State Annuity Board which has charge of the teachers' pensions that there are now over 12,000 Wisconsin teachers contributing to the pension fund and that there are 500 teachers that are drawing pensions from the fund.



AN IMPORTANT SUBJECT

We devote the column in this issue to an opinion by the Attorney General which will be of wide-spread interest. The Attorney General holds that the definition of "Treating the Sick," enacted as part of the Basic Science Law of 1925, is sufficiently broad to prohibit the practice of agents who sell systems of treatment and give advice as a part of the sales. No greater blow has been dealt this definite field of unlicensed quackery which is so prevalent in many cities of the state. The opinion follows:

Mr. Raymond E. Evrard, April 21, 1927
District Attorney,
Green Bay, Wisconsin.
Dear Sir:

You inquire whether the sale of a Magnecoil Blanket is in violation of Ch. 147, when sold by an agent, pertaining to the definitions referring to sec. 147.01 and sec. 147.02 of the statutes.

You state that agents were selling the Magnecoil Blanket in your vicinity and that the Wisconsin state board of medical examiners are complaining that it is in violation of the law. You state that the agents are not holding themselves out as practitioners, and you enclose a pamphlet referring to the Magnecoil system for my aid in determining the question submitted.

On page 17 of said pamphlet I find the following:

"WHAT THE MAGNECOIL IS

"It is a Thermo-Electro-Magnetic Blanket, made scientifically of the very best materials obtainable.

"It contains twelve hundred feet of Magnecoils. These coils intensify the magnetic field.

"It develops just the necessary amount of magnetism and magnetic heat.

"It has an Induction Pad and Boots which concentrate the magnetism wherever they are applied.

"* * *."

Upon the same page we find the following:

"WHAT THE MAGNECOIL DOES

"It generates Thermo-Electro-Magnetism.

"It imparts soothing, relaxing, rest-producing influences.

"It induces seven thousand two hundred electro-magnetic waves through the body every minute it is in use.

"It normalizes the circulation of all fluids and assists the transmission of nerve impulses.

"It invigorates exhausted nerves and weak organs.

"It causes the blood to enrich itself with more oxygen and absorption of food.

"It produces increased circulation and normal warmth of the body.

"It causes the body to create its own electrical energy in abundance.

"It dissolves poisons by electrolysis and prepares them for elimination.

"Through increasing vital activity, the action of all organs and tissues of the body is increased.

"It successfully and constructively treats acute and chronic diseases in a natural way, because it produces conditions of health."

On page 18 a great many things are given as affected by thermo-magnetism. I will mention only a few:

"It generates molecular activity.

"It increases life processes in the cells of the body.

"It causes the iron in your blood to combine with oxygen.

"It oxidizes the waste matter in your system and drives these substances to the natural organs of elimination where it forces them out of your body forever.

"* * *

"It reestablishes nervous equilibrium.

"It produces chemical changes necessary to life.

"It creates vital electricity in the tissues.

"* * *."

On page 21 we find the following:

"THE REPRESENTATIVES OF THE MAGNECOIL COMPANY

"They are ladies and gentlemen whose business it is to see that you get the very best service from your Magnecoil.

"They represent a natural health service and will see that you understand and carry out instructions.

"They are not salesmen—many of our representatives do not know the first principles of selling.

"They are the necessary link to connect the patients with the service that makes them well.

"They are progressive men and women who are inspired by a desire to be of service to you.

"They are instructed in the principles of natural treatment."

You will note particularly that the representatives of this company contend that they are not salesmen. On page 21 we also find this:

"The Magnecoil has won its great reputation because it has brought about cures in the most difficult chronic cases."

In sec. 147.01, subsec. (1) (a) the following definition is given:

"To 'treat the sick' is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof."

In sec. 147.02 all persons are prohibited from treating the sick or attempting to treat the sick without a certificate of registration in the basic sciences, etc., and shall have complied with all other requirements of law.

On page 10 of the pamphlet we read of the Magnecoil system of treatment. Those that sell it are not holding themselves out as salesmen, but they ask to be consulted in the use of this Magnecoil system of treatment in concrete cases.

I am of the opinion that your question must be answered in the affirmative. The representatives who are not salesmen but advisers of the patients are violating the provisions of secs. 147.01 and 147.02 of the Wisconsin statutes and other statutes pertaining to the licensing of practitioners.

Very truly yours,

J. E. MESSERSCHMIDT,

JEM: EWL Assistant Attorney General.

Approved:

John W. Reynolds,

Attorney General

Caption:

The agents who sell the Magnecoil system of treatment under the plans and practices of that system of treatment are violating secs. 147.01, 147.02, and other statutes regulating the practice of the healing art.

ALOE'S REMOVAL

The well known surgical supply house of A. S. Aloe Company in St. Louis has been crowded out of their contracted quarters at 513 Olive Street (the optical store remains there), and are now located in the new Aloe Surgical Building at 1819-23 Olive Street—only three blocks from the Union Station. The removal was necessitated by lack of downtown parking facilities and the growth of their surgical business which required larger and better quarters. Visiting physicians should take note of the new location near the railway center

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P. H. E. PAMPHLET ISSUED

A pamphlet to the laity on "Periodic Examinations of Apparently Healthy Persons" has just been issued by the State Board of Health. Arrangements are being made for the reprint of these pamphlets so as to make them available in quantity to all members of the State Society. Announcement of these plans will be made in the July issue of the Journal.

Résumé and Status of Bills of Interest to Physicians; Assembly and Senate Action to June First Listed

AFFECTING MEDICAL PRACTICE

274A—Petersen. The present law provides that dentists may secure alcohol for the purpose of sterilizing their instruments without payment of a permit fee. This bill extends the same privilege to physicians and veterinarians.

Recommended by Assembly Committee on Public Welfare. Advanced by Assembly. Recommended by Joint Committee on Finance. Advanced by Assembly. Passed by Assembly 78-1. Passed by Senate. Signed by Governor.

AFFECTING MEDICAL LICENSURE

68A—Hinckley. The present law provides that a physician convicted of a crime in the course of his professional conduct shall have his license revoked. This bill provides that the court "may" do so instead of "shall," and further, should the license be revoked, empowers the court to restore the license.

Killed by Assembly; reconsidered 52-31; amendment introduced; re-referred to Committee on Public Welfare.

The amendment so changes the bill that when adopted the bill will then only provide that in cases where a physician's license has been revoked for a first offense, it may be restored by the Court upon written approval of the President of the State Board of Medical Examiners.

Substitute offered by State Medical Society clarifying and adding requirements. Substitute adopted by Assembly. Passed by Senate. Pending before Governor.

239A—Withrow. This bill is introduced by request of the State Board of Medical Examiners. It provides for an appropriation of $5,000 annually to the board for the purposes of law enforcement efforts.

Recommended for passage by Assembly Committee on Public Welfare. Advanced by Assembly 86-3. Referred to Joint Committee on Finance. Recommended for passage 13-0. Advanced by Assembly. Passed by Assembly 73-1. Recommended for killing by Senate Committee on Public Welfare, Senator Englund dissenting. Senate refused to kill 8-22. Passed by Senate 23-7. Pending before Governor.

416S—H. H. Smith. This is an eighteen-page bill enacting an entirely new State Narcotic Act. Proponents of the measure are federal narcotic officials. The bill would entwine the state law with the Harrison Narcotic Act (federal). The bill was full of objectionable features to physicians.

The State Medical Society proposed substitute amendment 1-S. This substitute amendment brings present State Narcotic Act to date and strikes out of the present act features objectionable to physicians.

Substitute amendment 1-S recommended for passage by Senate Committee on Education and Public Welfare. Pending in Senate.

GENERAL HEALTH MEASURES

219S—Teasdale. A bill to empower the State Board of Health to adopt and enforce rules and regulations governing the purchase, sale and distribution of shoe dyes, poisonous fireworks, cosmetics, or other poisonous or noxious products other than food or drug products. This bill carries out preventive measures suggested by the American Medical Association.

Amended to drop word "cosmetics." Passed by Senate. Killed in Assembly.

182S—Hunt. This measure provides that lye shall be labeled as poison and two antidotes listed on the label. This is a uniform state bill fostered by the American Medical Association and the State Medical Society of Wisconsin.

Passed by Senate. Passed by Assembly. Recalled for corrective amendment. Amendment adopted. Pending before Governor.

470A—Assembly Committee on Public Welfare. This bill, introduced by request of the State Board of Health, aimed to make clear the fact that a violation of present State Quarantine Law was a misdemeanor, and provided penalties.

Chiropractors introduced amendment 1A to provide that they might attend cases of contagious diseases on the same basis as physicians.

Amendment 1A adopted in Assembly, 56-25. Bill as amended advanced 45-44. Refused to kill 26-39. Passed by Assembly 43-22. Recommended for killing by Senate Committee on Education and Public Welfare. Killed by Senate 13-5. Motion for reconsideration pending.

505S—Senate Committee on State and Local Government. This bill provides that the town chairman, village president, mayor, or chairman of the county board, can authorize temporary medical relief for a poor person "and liability for expenses so incurred shall be the same as though incurred by the board or council."

This bill was introduced at the suggestion of the State Medical Society.

Recommended for passage by Senate Committee on Education and Public Welfare. Passed by Senate. Pending in Assembly.

558S—Senate Committee on Judiciary. This bill appropriates to the State Board of Health $10,000 a year for the purpose of employing two state narcotic inspectors.

Pending in Senate.

635A—Assembly Committee on Municipalities. This bill provides that the secretary of the State Board of Health shall be a full-time officer "and shall not engage in the private practice of treating the sick for compensation." This bill writes into the law what is now the present practice.

Pending in Assembly.

RELATING TO INSANITY

156S—Senator Sauthoff. The main features of this bill are: (1) Denies subsequent re-examination of a person committed as insane for a period of six months from commitment and, (2) substitutes a jury of three physicians to decide question of sanity when such trial is demanded, instead of a lay jury, "each juror shall receive $15 as compensation."

Pending in Senate.

550S—Senator Hunt. The main features of this bill are: (1) Re-writes, at suggestion of Board of Control,

the examination blank used by physicians in determining sanity and, (2) makes more certain that the state does not pay for maintenance of a person adjudged as insane whose estate is sufficient to pay for institutional care.

Pending in Senate

559S—Senate Committee on Judiciary. This bill, introduced at the suggestion of the State Medical Society, makes a jury permissive in insanity cases only upon decision of judge.

Pending in Senate.

560S—Senate Committee on Judiciary. This bill, introduced by the suggestion of State Medical Society, provides for licensing and inspection of private sanitariums and for commitment thereto, if desired, by relatives.

Pending in Senate.

561S—Senate Committee on Judiciary. This bill, introduced at suggestion of the State Medical Society, increases the fees for judge and examining physicians to $10 per day.

Killed by Senate.

Senate Rejects Chiropractic Proposal; Passes Law Enforcement Appropriation Over Adverse Committee Report

Chiropractors were refused the right to attend cases of contagious disease when the Senate killed an amended assembly bill for that purpose by a vote of 13 to 5. The bill had been recommended for killing by the Senate Committee on Public Welfare with a unanimous vote after representatives of the Wisconsin Chiropractic Association and Assemblymen Henry Staab, Milwaukee, and D. J. Vincent, Kenosha county, had pleaded for at least a two years' trial. Senators voting against the proposal in the committee were Titus, Fond du Lac; Englund, Wittenberg; Teasdale, Sparta; Goodland, Racine and Hunt, River Falls. A motion for reconsideration is pending.

The second week in May the same committee voted to recommend for killing the Assembly bill 239 appropriating to the Board of Medical Examiners the sum of $5,000 a year for the next two years only for the purpose of weeding quacks out of the state. Senator Englund dissented from the Committee report. When the bill came to a vote in the Senate the following week a long discussion followed resulting in overturning the committee report and subsequent passage of the measure, now pending before the Governor for his approval.

The fight for the bill was led by Senator Oscar Morris, Milwaukee, who pointed out that ever since its inception thirty years ago the Board of Medical Examiners had been a self-sustaining board.

"Two years ago," said Senator Morris, "a campaign was opened to the end that this board might accomplish as effective results in law enforcement as in the field of licensure. It is not sufficient that this board remain a purely licensing body if the made on this floor."

public is to have the protection in fact that the law contemplates. The board must follow up after licensure to establish those who are engaged in quackery. This proposal comes from the medical men of the state and I know of no body more deeply interested in public welfare."

"Similar efforts to those made possible if this bill passes have been going on in Illinois and other surrounding states," declared Senator George Blanchard, Rock county, "and as result those driven out of neighboring states find refuge in Wisconsin. The legislature cannot afford to frown upon this movement. The legislature cannot afford to even injure or delay work conducted to eliminate the bloodsucker who is out to obtain money under false pretenses. We owe it as a duty to ourselves and the public to frown on the practice of quacks and, by granting this very small appropriation for a very limited period, drive them from this state."

The bill was opposed by Senator Hunt, River Falls, who said that it represented a movement to crowd out the cults and that while he always sought the advice of the M.D., he did not believe that such movements should originate from a body that were in fact competitors of the cultists.

"I am a friend of the State Medical Society," said Senator Hunt, "and have had the pleasure of introducing bills for them. I respect the physician and will do anything within reason to help them in their public spirited efforts. At the same time I am democratic and in this instance believe they have overstepped themselves."

"I have been at these law enforcement conferences," answered Senator Morris, "and I never heard anyone present even mention any cult. I am shocked that any such intimation should be made on this floor.

"I may be wrong," said Senator Hunt. "That was just the impression I gathered."

"The people we are after are the bloodsuckers," responded Senator Morris. "They are driven from other states because of their vile, contemptible practices. They must not find a safe haven in Wisconsin."

Senator Teasdale, Sparta, expressed the opinion that the measure was but an opening wedge for further appropriation requests in the future.

"I am not in favor of putting any legitimate practitioner out of business," said Senator W. L. Smith, Neillsville, conservative leader and chairman of the joint committee on finance. "It does appear, however, that even the medical profession has those within its ranks who are not qualified or who abuse their license. I do not feel that this money will be used to put any legitimate practitioner out of business. If they do what they claim they can do with this small appropriation it will be to the very great advantage of the people of the state. I am convinced of the need, of the sincerity of purpose, and I think this appropriation will be a good thing."

Senator W. L. Goodland, Racine, declared that he was for the purpose but felt that the work could be done locally without the appropriation.

"I want to present another viewpoint to this body," declared Senator C. B. Casperson, Polk county. "We have had quacks in our section of the state that we have ridden out of town on a rail. But this is the point,—how are the people out in the 'brush' going to know whether a man is what he claims to be if the state does not enforce this law. It is the people 'up in the brush' who suffer. I am for this bill and I hope it passes by a large majority."

ROLL CALL

When the roll was called the Senate voted 22 to 8 against killing the bill. The vote follows:

To kill the bill: Senators Cashman, Kewaunee county; Goodland, Racine county; Hunt, Pierce county; Hutchison, Mineral Point; Polakowski, Milwaukee; Schumann, Watertown; Severson, Waupaca county and Teasdale, Sparta—8.

For the bill: Senators Blanchard, Rock county; Boldt, Sheboygan Falls; Caldwell, Lodi; Carroll, Glidden; Casperson, Frederic; Chase, Oconto; Daggett, Milwaukee; Englund, Wittenberg; Gettelman, Milwaukee; Hull, Whitewater; Johnson, Superior; Keppel, LaCrosse; Lange, Eau Claire; Markham, Horicon; Mehigan, Milwaukee; Morris, Milwaukee; Mueller, Wausau; Roethe, Fennimore; Sauthoff, Madison; H. H. Smith, Milwaukee; W. L. Smith, Neillsville; and White, Winneconne—22.

Absent: Barker, Ruffing and Titus—3.

PENDING BEFORE GOVERNOR

As this Journal goes to press the bill is pending before the Governor for his signature. The legislative record of the bill includes unanimous approval of the Assembly committee on public welfare and of the joint committee on finance; advancement in the assembly 86-3 and passage 73-1; refusal to kill in the Senate 22 to 8 and passage 23-7.

ALCOHOL BILL SIGNED

During the third week in May Governor Fred R. Zimmermann gave executive approval to a bill by Mr. Fred Peterson, R. M., Milwaukee, providing that physicians desiring to use alcohol for sterilizing their instruments might obtain a state permit for that purpose without a fee. Formerly a $10 fee was charged. This bill, introduced at the suggestion of the State Society, met with no opposition in either house of the legislature.

As stated in former issues, the Governor has also approved two other State Society bills providing for a revision of the legislative charter creating the State Society, and making needed amendments in the licensure law affecting physicians.

During the first week in June the Governor will receive the model state lye bill as advocated by the American Medical Association. This bill provides that lye and like caustics shall be labeled as "Poison" and that each label shall list antidotes. The purpose of this measure is to lessen the number of cases of accidental lye burns to children resulting from carelessness in the handling of the solutions in the household.

SESSION NEARS END

Though there were 500 bills yet to receive action as of June first, it appears probable that the active work of the session will be over by the first of July. All major recommendations of the State Society are in bills which have either already received executive approval or in measures now pending before the Governor. Several other bills still remain before the legislature including four bills dealing with reforms in the method of committment and release of the insane. A fifth bill makes needed revisions in the state narcotic law while a sixth bill provides that the town, village or board president may authorize medical attendance in poor relief conditions. This bill, 505S, has passed the Senate and is pending before the Assembly. Its purpose is to correct a situation existing particularly in the northern part of the state where physicians attend poor patients upon oral authority only to find that such authority is not sufficient and to have their claim subsequently denied by the board in session.

Annual Meeting Program Nears Completion; Eau Claire Arrangements Promise Attractive Session

With the completion of entertainment plans and the near completion of the scientific program, all plans are now settled for the 86th annual meeting of the State Medical Society of Wisconsin to be held at Eau Claire on Wednesday, Thursday and Friday, September 21st, 22nd and 23rd. Close to 200 health officers will visit the annual meeting as result of arrangements which permit the Biennial Conference of State Health Officers to open in Eau Claire the day preceding the state meeting. A joint session will be held on Wednesday morning. This conference will commemorate the 50th anniversary of the State Board of Health.

According to present plans the scientific program on Wednesday will include subjects in the field of public health of interest to the general practitioner, while Wednesday afternoon will be devoted to subjects in the field of internal medicine. The public meeting will be held Wednesday evening followed by a smoker for the members at the Elks' Club. Thursday will be devoted to aspects of surgery, major and minor, developing from injuries in industry together with a symposium on general surgery. The annual dinner will be given Thursday evening.

An innovation of the meeting will be a symposium on Friday morning on methods of examination of use in general practice. Five speakers will present the fields of orthopedics, neurology, urology, pediatrics and obstetrics. Friday afternoon will be devoted to guest speakers in the field of internal medicine and eye, ear, nose and throat.

Among the guests of the society will be Drs. R. B. Preble, Chicago; Peter Bassoe, Chicago; Lewis J. Pollock, Chicago; I. A. Abt, Chicago, and Mr. L. A. Tarrell, Milwaukee, formerly member of the Industrial Commission of Wisconsin.

An unusually advantageous place of meeting has been secured, just four blocks from the main hotels. An entire building will be devoted to the large session hall and hall for exhibits. The House of Delegates will hold its first meeting Tuesday evening, September 20th, at the Eau Claire Hotel and will hold subsequent meetings on Wednesday evening and Thursday morning. An important question before the House of Delegates will be a proposed amendment, laid on the table at the last meeting, to provide that councilors shall be elected by the councilor society at the district meeting rather than by the House of Delegates. The preliminary scientific program will be published in the July issue of the Journal. The program by days follows:

Academy where exhibits and scientific sessions will be held

Sacred Heart Hospital, Eau Claire

PROGRAM, WEEK OF SEPTEMBER 20TH

Tuesday, Sept. 20th—

Biennial Conference of State Health Officers.
Erection of exhibits, Academy.
Golf Tournament.

4:30 P. M. Council supper meeting—Eau Claire Hotel.

7:00 P. M. Registration for House of Delegates, Mezzanine Floor, Eau Claire Hotel.

7:30 P. M. House of Delegates, First Session.

Wednesday, Sept. 21st—

8:00 A. M. Registration and exhibits open, Fournier's Academy.

9:00 A. M. First Scientific Session — Joint meeting S. M. S. and Biennial Conference of State Health Officers.

12:30 P. M. Council luncheon meeting, Eau Claire Hotel.

Afternoon entertainment for ladies.

1:30 P. M. Second Scientific Session.

Luther Hospital, Eau Claire

6:00 P. M. Exhibit Hall closes.
7:00 P. M. Second Session, House of Delegates, Eau Claire Hotel.
8:15 P. M. Open Meeting, High School Auditorium.
10:00 P. M. Smoker, Elks' Club—Members only.

Thursday, Sept. 22nd—
8:00 A. M. House of Delegates, Third Session. Exhibit Hall opens.
8:30 A. M. Third Scientific Session.
12:15 P. M. Alumni Luncheons. Luncheon for ladies and entertainment.
2:00 P. M. Fourth Scientific Session.
6:00 P. M. Exhibit Hall closes.
7:00 P. M. The Annual Dinner. (For members, wives and guests.)

Friday, Sept. 23rd—
8:00 A. M. Exhibit Hall opens.
8:30 A. M. Fifth Scientific Session.
12:15 P. M. Luncheon Meeting, Radiological Section.
1:30 P. M. Sixth Scientific Session.
2:00 P. M. Exhibits closed.
5:00 P. M. Meeting ends.

University Extension Program Reorganized; Four Special Fields of Work to be Developed During Two Year Period

Following joint meetings attended by Dean Chester D. Snell, Extension Division, University of Wisconsin, Medical School representatives and representatives of the State Medical Society, the Division announces the formulation of the medical extension program for the two year period ending July 1, 1929. Four fields of effort will feature the reorganized program. These are:

1. Medical literature and clinical case report service for individual physicians.
2. Lecturers for county medical society programs to be supplied without expense.
3. Short post graduate courses at the University (effective 1928).
4. Special lecture—clinical groups (effective 1928).

In presenting this program upwards of $18,000 will be expended in the various fields during the two year period and as result a wealth of material will be made available to both the individual physician and the county medical societies. The outline adopted was result of a general preliminary conference attended by President Glenn Frank of the University, Dean Chester D. Snell of the Extension Division, Drs. C. R. Bardeen, W. D. Stovall, F. W. Lorenz, R. C. Buerki and Joseph S. Evans of the Medical School together with Dr. Rock Sleyster, Dr. O. B. Bock and Mr. J. G. Crownhart of the State Medical Society.

Final organization was completed at a subsequent meeting at which it was decided that the extension work would be offered under joint auspices of the Extension Division, the Medical School and the State Medical Society. The executive committee is composed of Dean Snell; Dr. A. W. Rogers, president of the State Society; Drs. C. R. Bardeen and Joseph S. Evans of the Medical School; and Mr. J. G. Crownhart, ex officio.

An advisory committee appointed by the President is composed of Drs. M. D. Bird, Marinette; Otho Fiedler, Sheboygan; I. G. Babcock, Cumberland; R. L. MacCornack, Whitehall and J. F. Wilkinson of Oconomowoc. This committee met in May to formulate and approve the final program.

LITERATURE SERVICE

The present package library service, based primarily on current literature and available without cost to individual physicians, will be greatly enlarged and its value enhanced with the early employment of a full time medical librarian. It is anticipated that the librarian of the type desired will be secured during the early summer and that the enlarged service will be ready by the early fall.

This service will be based upon articles from current medical literature including all publications of the American Medical Association, practically all state medical journals and other major publications. Packets on any subject desired will be made up upon request by the individual physician. There will be no charge for this service other than the cost of the return postage. The field of authoritative publications will be supplemented by books from the University library, already available.

Beginning with an early number of this Journal, the Extension Division will edit a special section on case reports which will be published to call attention to major medical and surgical principles involved. This section of the Journal will be prepared under the supervision of Dr. F. W. Lorenz. The packet library service will be under the advisory council of Dr. Bardeen, Dr. Rogers and Mr. Crownhart.

MEDICAL SOCIETY PROGRAM MATERIAL

Regardless of size or location, every county

medical society in the state is now offered as a basis for program material the services of all on the medical school staff and the preceptorial staff (members listed in the correspondence column of this issue) all of whom will appear on programs without any cost to the county societies. All expenses of these speakers will be paid from the Extension Division funds and honorariums, formerly paid by county societies, are abolished. This procedure will emphasize the fact that the speakers are guests of the Society, appearing without remuneration except for their expenses, paid by the Extension Division.

This service will be developed with advice from the special advisory committee and is placed under the immediate supervision of Dr. R. C. Buerki and Mr. J. G. Crownhart. All requests for program material should be made direct to Dr. R. C. Buerki, State of Wisconsin General Hospital, 1300 University Avenue, Madison. Requests for service will be made preferably on the basis of subjects desired or not desired rather than for individuals. It is explained that it is often hard to secure a given individual for a specific date while if requests are made by subject matter desired, more than one speaker is available in each field.

The Division plans to spend $2,500 a year in completion of the efforts announced in this field. It is pointed out that where societies are small and distant from Madison, joint meetings can often be arranged for the convenience of members and speakers alike.

SHORT COURSES

Effective in 1928 the University Medical School will offer short review courses of a few days' duration for the convenience of all physicians in the state. The subjects of these courses will be in the field of remedial agencies and will not be of a general nature. These courses will be organized by Drs. J. S. Evans and R. C. Buerki of the Medical School and Dean Snell.

LECTURE—CLINICAL GROUPS

A feature of the reorganized program will be special lecture clinical groups on the North Carolina plan which will be opened for registration in the spring of 1928. In this field six groups will be established who desire a lecture and clinic on a given field once a week for a six or ten weeks' period. Expense of securing the speaker and organizing the clinical material will be shared alike between the individuals desiring to take the special home work and the Extension Division. These courses will be organized under the direction of Deans Bardeen and Snell and Mr. Crownhart.

Further announcements on the progress of the plan outlined will be made from time to time in the columns of this Journal but this immediate announcement is made for the information of county society officers and individual members throughout the state.

University Graduates Its First M. D.'s and Nurses in June; Service Memorial Institute*

BY C. R. BARDEEN, M.D.
Dean of the Medical School,
Madison

For the first time next June the University will grant the doctor's degree in recognition of long and successful preparation for a profession based on science and social service, the profession of medicine. There are twenty-five in the graduating class of whom six are women.

It is becoming increasingly evident that the chief responsibility for the preparation of practitioners to meet public needs rests upon the state universities.

The state universities and the more heavily endowed private universities alone have sufficient resources to offer the extensive laboratory and hospital training now required for medical practice. The endowed universities have been tending more and more to recognize as their first duty the advancement of medical knowledge toward a point of view that teaching must not be allowed to interfere with scientific research.

Thus the responsibility for training physicians to meet the general needs of the commonwealth is falling upon the state universities, and these have a responsibility to the community which the endowed universities do not have.

They must furnish an opportunity to the youth of the state to prepare for a noble profession. They must furnish trained practitioners in sufficient

*From the Wisconsin Alumni Magazine, May, 1927.

numbers to meet the needs of the state. They must make available to those who are in active practice the scientific procedures and scientific knowledge which come from the rapid progress of medicine. They must aid the people of the state to keep in touch with the progress of medicine and hygiene.

The skillful family practitioner is more needed than ever before. Today such men are being produced in numbers insufficient to keep up the needed supply. The complete medical course at the University has, it is hoped, been established in time to prevent a dearth of physicians in Wisconsin from becoming serious. At present the medical school cannot, because of lack of space and restricted staff, meet all the demands made upon it for medical training. The Service Memorial Institute Building, now in course of construction, will do much to relieve the present lack of space, although it will not furnish all the space needed to meet existing demands.

In the development of the clinical part of the medical course at the University, special attention has been paid to training students to understand the needs of the state. The two or more years of premedical work required for matriculation in the medical school and the first two years of the medical course are devoted chiefly to the study of the sciences on which medicine is based. Each student writes a thesis on a scientific subject. The third year of the medical course is devoted chiefly to basal training in the art of applying this scientific knowledge to meeting the problems presented by the sick. This work is carried on at the Wisconsin General Hospital under the careful supervision of the members of the staff.

Instruction during the fourth year of the medical course is based on the preceptor system and requires at least 48 weeks for completion. Each student is assigned for given periods to a series of preceptors in medicine, surgery, obstetrics, public health, and the chief medical specialties. About half of this work under preceptors is taken at the Wisconsin General Hospital, and about half in other institutions. During the past year our students received instruction at the State Hospital at Mendota; at one of the three local Madison Hospitals, the Madison General, the Methodist, or St. Mary's; at the Milwaukee Children's Hospital and the Milwaukee City Dispensary; and at the Chicago Lying-In Hospital. Each student likewise worked under preceptors for three months in one of the following cities: Oshkosh, La Crosse, Eau Claire, Marshfield, Wausau, and Ashland. It is planned to extend this service to other medical centers in the state and other preceptors. The preceptor plan as carried out here is something new in medical education, but gives promise of being a success.

Each candidate for the degree of Doctor of Medicine is required to present a thesis bearing upon some social aspect of medicine. Since each of these students has previously presented a thesis on some subject in medical science, each is required, in the course of his preparation, to give thoughtful consideration to both great aspects of medicine, the scientific and the social.

FIRST GRADUATE NURSES

Next June the University will grant for the first time a certificate of Graduate Nurse. In connection with the Wisconsin General Hospital and the Medical School, there was established at the University in 1924, a School of Nursing. One three-year and two five-year courses were inaugurated. For the three-year course one semester of college work and thirty-two months of professional training in residence are required. This course leads to the certificate of Graduate Nurse. For the five-year course, three years of academic work are taken either in the Course in Home Economics of the College of Agriculture, or in the College of Letters and Science. This is followed by 27 months of professional training in nursing. Both courses lead to the certificate of Graduate Nurse. The Home Economics Course leads to the degree of Bachelor of Science, Home Economics; the Letters and Science Course to the degree Bachelor of Science, Hygiene.

The School of Nursing at Wisconsin is a school with college standards for entrance, class room and laboratory work. The ward work is carefully supervised by experienced instructors so that, while it has a practical value in adding to the care received by the patients, it has real educational value from the standpoint of the student. It is already recognized as among the foremost schools of nursing in the country.

There are eleven students in the class to be graduated next June. There are now eighty-four students in the School. The number in each successive class has rapidly increased as the school has become more widely known.

SERVICE MEMORIAL INSTITUTE

A memorial building to house laboratories for

the medical sciences is now in course of construction on the lot opposite the Physics-Economics Building on Charter Street. A view of this building as it will be seen from the corner of Charter Street and Linden Drive accompanies this sketch. It is directly west of Sterling Hall. The main building is to be five stories high and will in addition, have some working space in the basement and in quarters on the roof. It will be connected by corridors on the first and third floors with the General Hospital.

Like the Wisconsin General Hospital, the Service Memorial Institute Building is a memorial to those who served in the World War. It is to be built and equipped from a balance in the Rehabilitation Fund. The necessary legislation was sponsored by the officers of the American Legion as an act of public service and received hearty support from the State Legislature, the Adjutant General, and the Governor at the 1925 session of the legislature.

The new building will house institutes for hygiene, physiology, physiological chemistry, pathology and medical bacteriology and parasitology, pharmacology and toxicology, radiology, and rehabilitation. It will contain the library of the medical school and lecture and recitation rooms. Provision for special quarters for an institute of anatomy and for the psychiatric institute must at present be postponed. Anatomy will continue to occupy quarters in Science Hall, and the psychiatric institute quarters in the Bradley Memorial Hospital.

Each of the institutes mentioned above has three primary functions to perform, scientific, teaching, and state service. The importance of advancing knowledge in the lines mentioned is obvious. Advance in the treatment of disease and the promotion of health depends primarily upon advance in scientific knowledge. The importance of professional training in the use of this knowledge, the training of students for the practice of medicine, public health, nursing, physical education and similar professions is likewise obvious. The importance of offering elementary training in certain of these branches as a part of a general education and the importance of offering advanced training in the various branches to produce experts is also clear, as is cooperation in making this knowledge widely available through university extension.

The feature that especially distinguishes these institutes as developed at Wisconsin from similar institutes developed elsewhere is the wide-spread direct state service in which all, to some extent, take part and which for some is the chief duty. Thus the Laboratory of Hygiene which will be housed in the new Institute of Hygiene, aids physicians and health officers throughout the state in prompt diagnosis of communicable diseases and in the determination of the purity of water supplies. It is the laboratory of the State Board of Health and has scientific supervision of the six cooperative laboratories maintained by that Board in various parts of the state. The Psychiatric Institute, the laboratory of the State Board of Control, which will not be housed in the new building but is located nearby, performs a similar service in making various blood and other tests for physicians throughout the state. The new Rehabilitation Institute is expected to be of direct service to those engaged elsewhere in the state with problems of rehabilitation and the new Radiological Institute is expected to have a radium plant from which radium emanation in capsules can be distributed at cost to qualified experts in the state for the treatment of cancer. The State Toxicologist performs important services in aiding officers of the law in cases of suspected poisoning, as well as in making public sources of danger of poisons. It is thus obvious that the new Service Memorial Institutes are destined to play a most important part in making scientific knowledge available for control of disease and promotion of health in the state and will constitute a splendid service memorial through service.

PERMIT FEE DUE

The Collector of Internal Revenue calls the attention of all physicians in the state to the fact that their narcotic permit must be renewed on or before July first. At the same time an inventory of narcotic stock on hand must be submitted. The inventory may be taken, however, on any date between January first and June thirtieth and it is suggested that inventories be taken early in June and application for new permit made at that time so that there may be no question of fines for delay.

As result of action by congress at the request of the American Medical Association, the old permit fee of $3.00 has been reduced to $1.00. All forms necessary have been mailed to physicians by the Collector of Internal Revenue but duplicate copies may be secured by addressing: Collector of Internal Revenue, Narcotic Division, Federal Building, Milwaukee.

THE JOURNAL BOOK SHELF

Hospital Housekeeping and Sanitation. By Nora P. Hurst, R. N. Price, $1.25. C. V. Mosby Company, St. Louis, 1926.

A Manual in Preliminary Dietetics. By Maude A. Perry, B. Sc., Director of Dietetics, The Montreal General Hospital, Montreal. Price, $1.25. C. V. Mosby Company, St. Louis, 1926.

A Primer for Diabetic Patients. By Russell M. Wilder, M. D., Section on Nutrition, Division of Medicine, Mayo Clinic. A brief outline of the treatment of diabetes with diet and insulin, including directions and charts for the use of physicians in planning diet prescriptions. Third edition, reset, 134 pages. Price, $1.50 net. W. B. Saunders Company, Philadelphia and London, 1927.

Human Pathology. A Textbook by Howard T. Karsner, M. D., Prof. of Pathology, School of Medicine, Western Reserve University, Cleveland, Ohio. With an introduction by Simon Flexner, M. D. Illustrations, 20 and 443, black and white. J. B. Lippincott Company, Philadelphia and London.

Modern Practice of Pediatrics. By William Palmer Lucas, M. D., Prof. of Pediatrics, University of California Medical School. Price, $8.50. The Macmillan Company, New York.

Medical Clinics of North America. Vol. X, No. 4, New York Number. W. B. Saunders Company, Philadelphia and London, 1927.

Four Thousand Years of Pharmacy. An outline history of pharmacy and the allied sciences. By Charles H. LaWall, Ph. M., Prof. of Theory and Practice of Pharmacy and Dean of the Philadelphia College of Pharmacy and Science. Illustrated. J. B. Lippincott Co., Philadelphia and London.

Medical Clinics of North America. Volume IX, Number V, Chicago number, March, 1926. Octavo of 206 pages with 34 illustrations. Per clinic year, July, 1925, to May, 1926: Paper, $12.00; cloth, $16.00, net. W. B. Saunders Company, Philadelphia and London.

Medical Clinics of North America. Volume IX, Number VI, Chicago number, May, 1926. Octavo of 202 pages including complete index to Volume IX, with 24 illustrations. Per clinic year, July, 1925, to May, 1926: Paper, $12.00; cloth, $16.00, net. W. B. Saunders Company, Philadelphia and London.

The Conquest of Disease. By Thurman B. Rice, M. D., Assistant Professor of Sanitary Science, Indiana University School of Medicine, and former State Health Commissioner of Indiana (The Macmillan Co., New York), is one of the first of the 1927 contributions to the literature of disease control. The author announces three purposes: (1) To set forth the more recent scientific information, (2) to make it interesting, (3) to emphasize the advances that have been made and to create confidence in the science of disease prevention.

Physiotherapy. Theory and clinical application. By Harry Eaton Stewart, M. D., President-elect American Academy of Physiotherapy, director New Haven School of Physiotherapy. Paul B. Hoeher, New York.

Electrothermic Methods in Neoplastic Diseases. (Desiccation and Coagulation.) Designed as a practical handbook of surgical electrotherapy for the use of practitioners and students. By J. Douglas Morgan, M. D. Illustrated with 36 engravings. Price, $2.50. F. A. Davis Company, Philadelphia, 1926.

Health Supervision and Medical Inspection of Schools. By Thomas D. Wood, M. D., college physician, adviser in health education, and professor of physical education, Teachers College, Columbia University, and Hugh G. Rowell, M. D., physician to the Horace Mann School, lecturer and assistant physician, Teachers College, Columbia University. Octavo of 637 pages, with 243 illustrations. Cloth, $7.50 net. W. B. Saunders Company, Philadelphia and London, 1927.

Pseudo-Appendicitis. A study of mechanical syndromes of the right lower quadrant simulating appendicitis by Thierry de Martel, surgeon to the Paris Hospital, and Edouard Antoine, attending physician to the Paris Hospital. Translated from the French by Dr. James A. Evans, formerly assistant radiologist, St. Antoine Hospital, Paris, France. Published in 1925 by the F. A. Davis Company, in cloth binding, 201 pages, with 41 engravings.

The Diseases of Infants and Children. By J. P. Crozer Griffith, M. D., Prof. of Pediatrics in the Graduate School of Medicine of the University of Pennsylvania, and A. Graeme Mitchell, M. D., Prof. of Pediatrics, College of Medicine, University of Cincinnati. Second edition, reset. Two octavo volumes totaling 1,715 pages with 461 illustrations, including 20 plates in colors. Cloth, $20.00, net. W. B. Saunders Company, Philadelphia and London.

The Fifth Avenue Hospital Clinics. First series, based on the material from the semi-monthly staff meetings. Illustrated. Paul B. Hoeber, Inc., Publishers, New York City, MCMXXVII. Price, $5.00.

Harelip and Cleft Palate Cheiloschisis, Uranoschisis and Staphyloschisis. By Matthew N. Federspiel, D. D. S., M. D. The C. V. Mosby Company, St. Louis.

BOOKS RECEIVED FOR REVIEW

Should We Be Vaccinated? A survey of the controversy in its historical and scientific aspects. By Bernhard J. Stern, Instructor of Sociology, Columbia University. Price, $1.50. Harper & Brothers, Publishers, New York and London, 1927.

Medical Clinics of North America. Vol. X, No. X, Boston number, March, 1927. Octavo of 311 pages with 34 illustrations. Per clinic year, July, 1926, to May, 1927. Paper, $12.00; cloth, $16.00. W. B. Saunders Company, Philadelphia and London.

A Text Book of Medicine. By 130 American authors. Edited by Russell L. Cecil, M. D., assistant professor of Clinical Medicine, Cornell University, Medical School, New York. Octavo of 1,500 pages, illustrated. Cloth, $9.00, net. W. B. Saunders Company, Philadelphia and London.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 153 E. Wells Street, Milwaukee, Wisconsin. These new books will be loaned for an inspection period only.

Examination of Children. By clinical and laboratory methods. By Abraham Levinson, M. D., Associate in Pediatrics, Northwestern University Medical School. Second edition, with 85 illustrations. Price, $3.50. C. V. Mosby Company, St. Louis, 1927.

For those who desire to acquire information concerning the examination of children and the various clinical and laboratory methods used, this small volume will prove of great service. It fills a particular need in pediatrics and although most of the subject matter can be found in other text-books, it is well to have one book which includes all the procedures used in the examination of children. The chapter on the examination of cerebrospinal fluid is espe-

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cially good, but this is to be expected. One can hardly use the chapter on Roentgenography as a guide, because it is too brief. There are a number of excellent illustrations and no one who reads this book can help but acquire valuable knowledge.—R. M. G.

Nineteenth Annual Conference of the American Association of Medical Milk Commissions and The Certified Milk Producers' Association of America, May 25-26, 1925, Chalfonte-Haddon Hall, Atlantic City, N. J.

Physicians interested in problems relating to the production and distribution of high grade milk will be interested in these proceedings. The various papers present such topics as "The Eradication of Tuberculosis", "Foot and Mouth Disease", "Deleterious Effect of Freezing on Physical and Chemical Properties of Milk". This is a good book for the pediatrist to glance over, as he cannot learn too much about milk, the most important food in medicine.—R. M. G.

Management of the Sick Infant. By Langley Porter, M. D., Prof. of Clinical Pediatrics, University of California Medical School, and William E. Carter, M. D., Instructor in Pediatrics, University of California Medical School, San Francisco. Third revised edition. Illustrated. Price, $8.50. C. V. Mosby Company, St. Louis, 1927.

This practical treatise on the management of the sick infant has won a permanent place in the field of pediatric text-books. The fact that three editions have been called for in five years shows that this volume has been appreciated by physicians. It deals primarily with treatment and secondarily with diagnosis. The first part considers various symptoms, such as cough, fever, etc., and the treatment of such symptoms. The second part is taken up with diseases of various organs and the first part, consisting of two hundred pages, is devoted to methods. A special feature first brought out by Porter and Carter is the illustrating of various technical procedures, such as sinus puncture, thoracenteses, etc. There is a valuable section on drugs and illustrative prescriptions.

This book forms an admirable companion volume to the standard pediatric text-book and is well worth while.—R. M. G.

Should We Be Vaccinated? A survey of the controversy in its historical and scientific aspects. By Bernhard J. Stern, Instructor of Sociology, Columbia University. Price, $1.50. Harper & Brothers, Publishers, New York and London, 1927.

This monograph will be of interest chiefly to writers and public speakers on sanitation and hygiene. It offers to them a very useful "source book" on the history of vaccination—particularly on the history of the controversies that have arisen in regard to it as a health protection measure.

The main purpose of the author has been "to analyze the psychological and sociological factors involved in the opposition". Most physicians would be disposed to attribute this opposition to simple stupidity, ignorance and credulity on the part of the dupes of conscious quacks and scatter brained "near-scientists". Without reading each word, I am not convinced that the author has added much of practical value to this opinion. But as intimated above, students with a special interest in the subject will doubtless find useful data in the compilation that has the earmarks of much careful study.—H. E. D.

Obstetrics for Nurses. By Joseph B. DeLee, M. D., Prof. of Obstetrics, Northwestern University Medical School, Chicago. Eighth edition, revised. Pages 635, with 266 illustrations. Cloth, $3.00, net. W. B. Saunders Company, Philadelphia and London, 1927.

One of the best proofs of the popularity of a book is the number of times it has been reprinted. The publishers have found it necessary to reprint the eight editions thirty-six times. It is one of the best if not the best American text for obstetrical nursing.

The author treats the subject of obstetrical nursing in the hovel or most modern hospital in his usual broad-minded manner. However, he is constantly striving to place it on a higher plane than that of any of the other specialties.

The text is well illustrated by drawings and photographs. The chapters on prenatal care and diet in health and disease were added in the seventh edition. These with the discussion on the mental state of the pregnant woman are among the most important chapters in the book. Preparation of the parturient for labor with iodine or mercurochrome and Gwathmey's synergistic obstetrical analgesia have been added. Identification of new-born babies as practiced at the Chicago Lying-In Hospital must be infallible. At least, a triplicate method is used. Dr. Witt has added invaluable chapters on the new-born child and infant feeding.

The author has developed a text-book which is a veritable gold mine for the undergraduate, a ready reference work for the graduate, a splendid guide for the visiting nurse and a great help to the instructress.—R. S. C.

A Manual of Gynecology. By John Osborn Polak, M. D., Prof. of Obstetrics and Gynecology, Long Island College Hospital; Prof. of Obstetrics in the Dartmouth Medical School. Third edition, thoroughly revised. Illustrated with 145 engravings and 12 colored plates. Price, $5.00. Lea & Febiger, Philadelphia, 1927.

Apparently this book has been written primarily for the use of the undergraduate medical student. The author in his customary simple and concise style has sifted the wheat from the chaff and as a result has given to the reader all that is worthwhile in gynecology.

He has included the many recent additions made to the literature in pathology, diagnosis and treatment. Subjects over which there is still considerable controversy are not given much space. The chapter on internal secretions is about as clear as that subject can be made at the present time. The author, however, has failed to mention anything about insulin or the female sex hormone.

The illustrations are not any too numerous but all of them are clear and to the point. Many of them are diagrammatic.

Operations are briefly discussed but completely enough for the purpose for which this manual is intended.

The book fulfills the requirements for the beginner in gynecology and is an excellent addition to American gynecology.—R. S. C.

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Riedel's Strumitis

(Continued from Page 309)

roidism although his basal metabolic rate was plus thirty-four per cent. The urine was essentially negative and a complete blood examination showed a normal red and white count as well as a normal differential count. His thyroid gland presented a moderate enlargement which was of a stony-hard consistency and a preoperative diagnosis of malignancy was made. It was decided to do a thyroidectomy and examination of the tissue was reported as Riedel's strumitis. At operation the gland was found to be so markedly adherent to the surrounding cervical structures and especially so to the trachea, that it was at first deemed advisable not to attempt any surgical procedure. Finally it was decided to undertake its removal and found necessary to make a longitudinal incision through the gland proper in order to free the trachea. After the trachea was entirely free, the gland was shelled out on both sides with much difficulty. The characteristic feature of the tissue was its woody-like consistency and the remarkably small amount of bleeding. The danger of the operation lies in injuring the surrounding structures, especially the trachea. It is very probable, had this patient presented himself earlier, the operation would have been much less difficult and the danger brought to a minimum.

Symptomatically, the patient is disturbed principally by pressure symptoms. The diffuse hardness and induration causes an interference with the functions of the neighboring structures. The slight dyspnea, which appears early may assume severe proportions when the trachea is compressed or distorted, causing what is known as a "goiter asthma". It may cause pressure on the blood vessels of the neck, thereby disturbing the circulation and interfering with the equable return of the blood from the heart and lungs. Pressure on nerves, especially the recurrent laryngeal, may cause partial or complete paralysis of one or both vocal cords. Usually there are no symptoms pointing toward any metabolic disturbance and the patient otherwise enjoys fair health.

Pathologically, the tumor is very hard and its consistency resembles cartilage. The cut section is opaque, yellowish and hard, due to the extreme degree of induration. Because of its consistency and fixity to the surrounding structures, it is very often diagnosed as malignancy. The early stage of this disease is "characterized by a diffuse round cell infiltration and the formation of numerous lymph follicles with prominent germ centers. The cells of the infiltration are lymphocytes, plasma cells and some phagocytes, all lodged in a delicate reticulum of collagen fibrils and fibroblasts poorly supplied with blood. A variable number of acini are filled with colloid and lined by fairly normal cells, but in the majority the vesicular structure is lost. Cellular degeneration proceeds simultaneously with hyperplasia and the debris is removed by phagocytosis. Fibrosis appears as glandular destruction progresses." Extra capsular extension is present histologically before it is recognizable clinically. It is densely fibrotic and forms adhesions to the vessels, trachea, nerves and muscles and tends to infiltrate these tissues. There is no evidence of malignancy microscopically.

The treatment of this disease is surgical. Cure has been effected by complete thyroidectomy. Resection of a small part of the tumor has been followed by resolution of the remaining portion in a number of cases reported in the literature. Removal of the gland is not difficult when the disease is limited to the gland proper, but there frequently develops extra-thyroidal lesions whereby the gland becomes markably adherent to the surrounding structures, and makes the operation difficult and dangerous, the success depending upon the judgment of the operator in not damaging the cervical structures.

X-ray and radium therapy has been used with variable results, some men reporting favorably while others report failures. Although there is no definite proof of any etiological relationship between oral infection and this disease, it appears highly suggestive that a relationship might exist, and the eradication of foci of infection within the mouth is indicated in addition to the removal of the diseased tissue.

Summary

1. Riedel's strumitis is a rather rare condition.

2. It is characterized by symptoms of dyspnea, dysphagia, etc., with usually no evidence of hypo- or hyperthyroidism.

3. Riedel's strumitis is very easily confused with malignancy clinically and should always be kept in mind when confronted with a diffuse hard enlargement of the thyroid gland.

4. Treatment of Riedel's strumitis consists in the surgical removal of the gland and the earlier it is carried out the less difficult the operation and the lower the mortality.

The Wisconsin Medical Journal

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Chronic Arthritis; Some Recent Advances in Diagnosis and Treatment*

By J. L. PORTER, M. D.,
Evanston, Ill.

The discussion of this subject of chronic arthritis is prompted by three very firm convictions which are the result of over twenty years' study in various forms of chronic arthritis: First, that success in treatment has been unsatisfactory because we have persisted all these years in thinking of all cases of chronic arthritis as constituting one class, and thinking that they were different forms of the same disease. Second, that pathologically and etiologically they fall into several distinct groups. Third, that we have been so enthusiastic in looking after foci of infection that we have overlooked the fact that the patient's joints were painful and we have neglected the joints. The most important thing in the treatment of chronic arthritis of any type is rest.

Incidentally, I have become impressed with the fact that seventy-five per cent of the cases eat too much and one-half of that number don't know whether they have normal bowel movements or not.

In 1910, Nichols and Richardson, of Boston, published an epoch-making article on the pathology of chronic arthritis. Since then little real advance has been made in our pathological knowledge, and the student up to date can do little better than read that article.

THREE GROUPS

However, instead of the two groups, the degenerative and the proliferative, which Nichols and Richardson described and which they have illustrated most beautifully, we have come to believe that we can better describe clinically the various cases with their differences in three groups, and we designate these as infectious arthritis, atrophic arthritis and hypertrophic arthritis.

The atrophic variety corresponds to the proliferative type of Nichols and Richardson; the hypertrophic corresponds to the degenerative type of Nichols and Richardson. But we see a great many cases that do not fall into those two categories.

INFECTIOUS GROUP

In the first, the infectious group, the trouble begins usually as an acute arthritis. It may follow any of the infectious diseases, such as acute tonsilitis, scarlet fever, or gonorrhea. The acute stage, in the course of a few weeks, subsides under rest and proper treatment, leaving a joint which is still diseased and which eventually becomes a chronic arthritis. The patient complains of a loss of motion, pain on attempted motion, and the joint looks swollen, which is due chiefly to the inflammatory involvement of the peri-articular tissues. It is apparent that the synovial spaces have been damaged or destroyed.

In your minds I am calling up a mental picture. A patient comes into your office with an enlarged, swollen joint, he limps in on a cane. You find upon examining the joint that there is a thick, boggy feeling about the joint, very little motion, and it is exquisitely tender to touch.

You take an x-ray picture and you find that the interior of your joint looks normal except for an adhesion shadow between the ends of the bones, the articular spaces are narrowed a little, and your whole picture is one of a periarticular exudate with an involvement of the interior of the joint, the synovia, and not the bone. The bone shows no changes whatever.

Upon inquiry you find that the patient has had a recent attack of gonorrhea or some other infectious disease and that the infection in the joint follows during a period of convalescence from the disease, usually followed with a very definite interval intervening. Such a case will go on to a chronic history. The patient will continue to use the joint and limp and have trouble for many months, and sometimes those cases come into your office so late in the disease that when you ask

*Stenographic report of a clinical demonstration presented before the 85th Annual Meeting, State Medical Society of Wisconsin, Madison, September, 1926.

them if they have had any acute infection they have forgotten all about it.

As time goes on and the pain and the symptoms gradually subside, the joint loses its motion and becomes eventually a stiff joint, and then the x-ray picture shows up dense fibrous adhesions between the articular spaces.

ATROPHIC GROUP

The second group is known as the atrophic arthritis. This type is most frequently seen in thin, poorly nourished subjects, much more frequently in women than in men, usually attacking the smaller joints first, such as the hands or toes (it rarely attacks the large joints first), and then the elbows and knees; the hips or the spine become involved afterwards.

The infection is chronic from the start, although there may be periods of improvement and exacerbation. Some of the joints may remain quiescent for months. The pathological process is substantially as follows: the synovia and the articular surfaces are first involved and adhesions take place between the synovial fringes and the edges of the capsule and the edges of the cartilage, and as the process goes on the joints become painful, stiff, possibly distorted, and the x-ray shows that the ends of the bones have faded away as the result of insufficient nourishment. We don't know of any better reason.

While these signs are oftentimes apparent at the outset, as time goes on the joint becomes less mobile and the pain becomes less. Examination reveals that the joint is practically stiff.

The outstanding characteristic of the atrophic group is that the patient shows signs of general atrophy; frequently the hair, the teeth, the nails, the skin, the muscles show a distinct atrophy. The feet and legs below the knees are sometimes covered with herpes. You see the patient come into the office with several joints involved and the spine so stiff that the patient cannot turn his neck when he wants to look anywhere. His hip is so stiff that he has to sit down with his leg sticking out in front of him. His knees are swoolen and bent nearly at right angles, and perhaps the toes and fingers are all out of shape.

He will invariably tell you that the trouble began in the smaller joints first. Rarely do you see that type of disease in a fat, over-nourished patient.

Sometimes the nails get all out of shape like the nails of a senile patient, and the atrophy is seen in the x-ray in the ends of the bones and the bones become roughened.

In this type of disease the interior of the joint is naturally not badly affected early as in the infectious type, but the bone shows a great deal more destruction and gradually the cartilage and the articular surfaces become involved, and adhesions take place and the joint becomes stiff and difficult of flexion.

HYPERTROPHIC GROUP

The third group is described as the hypertrophic arthritis group, which presents a very different picture both pathologically and clinically.

A patient usually past forty-five, a man or woman (the incident seems to be about equal in the two sexes), who is over-stout, usually, or well nourished, comes limping into your office and says, "Doctor, I have had a pain in that knee for four or five months, but only just lately it has gotten so I can scarcely use it."

You find that he complains usually of one joint, rarely of two, and almost never of multiple joints. Upon examination you find one knee is markedly larger than the other, extreme flexion and extreme extension are impossible, although motion seems quite free. Upon motion of the joint a rough grating may be felt or even heard. I am using the knee as an illustration because the knee is attacked in that kind of disease more frequently than any other joint in the body unless it is the spinal column.

The tissues around the joint feel boggy and infiltrated, and in certain areas they may be very sensitive to pressure.

The x-ray picture shows the articular space to be narrowed; around the edges of the tibia, on the posterior surface of the condyles and the edges of the patella there is distinct thickening overgrowth lipping of the joints. How many times have you seen x-ray pictures with distinct hypertrophies sticking up around the edges of the tibia or the anterior-lateral parts of the spinal column?

If the joint be opened, it will probably be found very much tinned as though from absorption, and it is sometimes absent in places. It is a fact that one of the characteristic pathological entities in this third type of disease is the absorption, the disappearance of cartilage in weight-bearing bodies, in the spine, in the hip, the knee, and if the patient continues the use of that joint the cartilages grad-

nally disappear. I have opened hip joints in which the head of the femur looked like the head of a billiard ball, absolutely no cartilage, yet around the edges of the acetabulum would be the exostosis.

I remember in one case the x-ray showed what seemed to be loose bodies in the joint. They apparently were attached to some kind of a joint, either the femoral neck or the capsule, and yet on prolonged treatment those exostoses disappeared completely. I was much surprised. They could not have been solidly organized in the bone, but they looked like it.

There is little or no fluid in these joints, but around the edges new bone has appeared and the synovial fringes in places seem to have undergone thickening and calcification.

I have succeeded in drawing for you a pathological picture of three distinct types of arthritis, and I am ready to proceed with the examination of this patient.

CLINICAL DEMONSTRATION

Here is a man forty-three years old who is a farmer. He has lived on a farm practically all of his life. Have any of your family ever had any similar trouble?

Patient: No.

Dr. Porter: Nearly three years ago now, the patient first noted pain in his big toe joint. During the summer the entire ankle began to be enlarged. The enlargement was accompanied by pain on motion. The condition remained the same until last spring. During the winter months the patient has been in Hot Springs, Arkansas, where he took daily baths. That was last winter. He has had his tonsils out, he has had eight teeth out, and he has been gone over very thoroughly in one or two other hospitals beside the hospital here, for foci of infection.

Upon his return from Hot Springs the right knee and the right hip joint began to trouble him, and the temporomaxillary joint was involved on both sides last December. The condition has been somewhat better, but the patient cannot even now open his mouth very wide.

Since April there have been pains in the lower extremities which seem to be felt in the muscles. The right arm has also been painful at times. The parts involved were painful and the pain was more marked when the parts were moved.

I will read the x-ray report after I have examined the patient.

Elimination of all foci of infection has been instituted with no result, and improvement has not been forthcoming. In addition, the patient now complains of palpitation, persistent constipation and bleeding hemorrhoids.

Physical examination was made when this patient went into the hospital, which was the sixth day of July, and reveals emaciation, inability to open the mouth wide. Examination of the heart and lungs showed no abnormality. There was a swelling of the right wrist which he still has, the right knee, the right ankle joint. The reflexes were exaggerated. Examination of the nose and throat revealed no foci of infection.

The blood count shows a secondary anemia with a hemoglobin of seventy-two and a red cell count of 4,850,000. You see there is a low hemoglobin, with practically a normal red blood count.

The blood Wassermann was negative, the blood chemistry negative, x-ray of the sinuses negative. Flouroscopic x-rays of the chest showed a peribronchitis. Dental x-rays showed some alveolar absorption about the teeth. The ankle joint shows involvement of both the bones and the soft tissues. The patient was discharged on the fourteenth of July from the hospital with a diagnosis of chronic infectious arthritis and secondary anemia.

He has a slight thickening and enlargement of two of the metacarpal joints. Motion is a little painful when it is carried to the limit.

The most interesting features are the legs. The trouble first began in the big toe joint. It does not bother him any more. It has recovered with very nearly normal motion.

The knee joint became involved after the others. There is no roughness in the joint of the knee. The motion is limited to perhaps three-quarters of the normal. If I attempt to extend the joint of the knee it is very painful.

In addition to the knee he has involvement of the temporomaxillary joints and some of the joints of the cervical spine. While I have been reading the history perhaps you have noticed that he has been watching me and listening to me with his head turned to one side and that motion of the cervical spine is limited. I have cervical spinal arthritis too, but I can beat him in the movements. He cannot bend his head to the side. He tells about having some pain in the neck.

The sequence of events has been the toe, the ankle, the knee, the wrist, the temporomaxillary joints, and the spine.

If you could all come up and feel of this joint you would notice the difference. I take hold of and articulate the left joint; it is soft and mobile. I can pick up the skin very easily all around the joint. But when I come to the right joint I feel a very distinct thickening underneath the fingers, which involves the soft tissues round about the joint, and the outlines of the knee are large; above the patella is a very thick, boggy feeling inside the joint; I can feel the synovia roll under the fingers, which cannot be felt in the normal joint. Your tactile sense, if you were blind, would show you that the patient has an inflammatory process involving not only the ends of the bones, which will be shown by the x-ray, but the periarticular tissues are thickened, and especially the intra-articular tissues can be felt rolling under the fingers.

I will complete the history by reading the x-ray report. This was made on the seventh of July after he went into the hospital in Madison. X-rays of the sinuses were negative. Stereoscopic x-ray of the chest

showed peribronchitis. Dental x-rays showed alveolar absorption about all teeth, which I have already told you. X-ray of the right knee showed atrophy of the soft tissues and bone with slight area of rarefaction just beneath the lateral meniscus. The ankle joint shows bony and soft tissue atrophy.

From what I said to you about the pathology of these different groups, I believe that this one illustrates beautifully the atrophic type of arthritis, in fact the x-ray picture speaks first of everything of the atrophy that has taken place in the bone. While the destruction in these joints has not gone on to the extent that it does in some joints, if I could show you the x-ray pictures you would see a very distinct atrophy.

To sum up, the man is past forty, he is middle-aged. He has a multiple arthritis which has gradually extended from one joint to another until it has reached the cervical spine. The x-ray pictures show a distinct atrophy. He has had all of the infected foci that could be found removed. He has one joint still persisting among the joints of locomotion that he is using, in fact two, because he is putting his weight on his spine.

I want to ask him one question, and he can answer it. Have you ever had the knee joint firmly fixed so that you could not move it and had your weight taken off of it so you could not step?

Patient: No, sir.

Dr. Porter: The case presents in my estimation a typical atrophic type of arthritis. I think in a 1926 number of the Journal of the American Medical Association Cecil and one of his associates published a paper on chronic arthritis in which they brought out two features: they brought out a group which they call the arthritis of the menopause because they see it so frequently in fat women who have passed menstrual age, and they also speak about atrophic arthritis being hereditary. This man says that he does not know of any history of arthritis in his family.

As regards the arthritis of the menopause, I think that is gumming up the situation a little bit because the changes in the joint are exactly what we find in the osteoarthritic group which I have described. I see no reason for making a separate group known as the arthritis of the menopause.

ETIOLOGY

Since we find that the symptomatology and the pathology in these three groups are different, why should we go on thinking that the etiology is the same? I do not believe it is. It would be useless to go into the discussion here of focal infections as the cause of chronic arthritis. The literature of the subject has already become so voluminous that few of us have time to read it. I believe that focal infections, meaning by that infections of the diseased tonsils, gall bladder, sinuses, and so forth, which are not acute enough to produce symptoms in themselves, may be the cause of distinctly infectious types of arthritis which are in the first group I described.

I believe that the atrophic type is not so much due to infection as it is to a disturbance of the chemistry and the metabolism of the body, and very like some disturbance of the functions of some of the endocrine glands is a factor in this type of diseases.

How else can we account for the general atrophy and the disturbance of function in so many tissues? In the hypertrophic type, however, we have rather a local process. It is distinctly chronic from the start. It is more likely to be in one joint or in two joints, but rarely in multiple joints. It may involve the upper end of the spine or the lower end of the spine or the middle, but not often the entire spine. The pathology suggests that the etiologic cause, whatever it may be, is an irritant and stimulates new bone production instead of being a destructive agent.

Personally I don't think you can find bacteria in the joints of either the atrophic or hypertrophic variety. A few claim that they have found bacteria in the joints. I do believe you can find bacteria in the joints of the first variety, the infectious group, if you begin early enough, but not after the fibrous tissue has organized in the joint.

The only destruction apparently that has occurred in the joint surfaces in the hypertrophic group are the surfaces which are in contact and especially in a weight-bearing joint.

Personally I believe that this last group is caused in much the largest percentage of cases by chronic persistent autointoxication, and in my experience the toxemia can be traced in at least seventy per cent of the cases to the intestinal tube. In fact, a large proportion of the patients give a distinct history of long, persistent, intestinal indigestion.

This patient has recently had some disturbance of the digestion. Whether he had it before or not I do not know.

As a youngster did you have any trouble with digestion?

Patient: No.

Dr. Porter: Did you ever have any serious illness?

Patient: No.

Dr. Porter: He had an attack of influenza, with constipation, eructations, and flatulence. Many have a mucocolitis. Further as an evidence of autointoxication these cases have either a low blood pressure, indicanuria, or a high total acidity of the urine, the perspiration or the saliva. Sometimes all three of these conditions are found in the same patient.

When a low metabolic index is present, we suspect a hypothyroidism. This is especially apt to be present in the atrophic group. I can find no record here at the hospital of the blood pressure. Perhaps Dr. Greeley knows whether it was taken. The patient says it was 122.

TREATMENT

There has never been anything but hopelessness in the treatment of chronic arthritis medically. Probably every drug in the pharmacopeia has at some time been prescribed, which is sufficient evidence of the futility of

drug treatment. The old Indian remedy of epsom salts and apple cider was probably as rational as any; at least it reduced the alkalinity of the blood and kept the bowels open.

If, as we assume, the cause lies in an infection, a toxemia, or in perverted metabolism, the logical treatment is to find, if possible, what is causing the disturbance and eliminate it, but besides that there is the additional problem of making the patient comfortable, of saving as much as possible of the function of the joint and putting him back to work.

Many of us have been so keen in our hunt for the suspected focus of infection that we have forgotten all about the joint. How frequently we see patients who have had all their teeth extracted, usually the tonsils removed, sometimes sinus and gall bladder or pelvic operations performed, and who still have the arthritis? Inquiry reveals, however, that they have been permitted to be up and about and attempting to use the affected joints.

Before outlining the usual routine of treatment which we have adopted for the various types of arthritis, I want to emphasize one point. Fifty years ago Thomas in Liverpool preached the doctrine of rest. He said that an inflamed joint would not get well while it functionated. He proved it, and he preached it, and it has been a long time soaking in, but it is just as true today as it ever was. I have seen patients brought before me in a clinic with a history of having had the tonsils and the teeth and everything else that could possibly be the source of trouble taken out and still they had the joint, and they will keep on having sensitive and painful joints until the joints are either immobilized or get stiff.

Frequently a patient will say to me, "Oh, you don't need to bother about that joint, that's all right," but when I come to move it I find it is stiff. The reason it is all right is because there is no motion.

In an experience of thirty years I have become convinced that Hugh Owen Thomas' conviction is as true now as then. Joints affected with arthritis of the atrophic or hypertrophic type will never get well so long as they are allowed to function. Those of acute origin, in which an acute infection can be demonstrated, may and sometimes do recover while some activity is permitted, but they get well and become absolutely stiff. So in treating any painful, sore or inflamed joint, the first requisite is rest.

The only way to secure absolute rest for the spine or for any of the joints of the lower extremity is to put the patient to bed. I insist upon the patient going to the hospital, for two reasons: a patient, man or woman, especially a woman, boss in her own home, has too much to do to be kept in bed unless taken to a hospital. It is extremely difficult to put a woman to bed in her own home when she has some inflammation or pain in one of her joints, and keep her there. The great temptation is to get up and go to the bathroom, if she doesn't do anything else. As they lie in bed in the house they hear every sound, the doorbell, the milk at the door, the butcher's wagon, and everything else, and they interpret every sound as one to get up and be active doing things.

If you put a patient in the hospital and take her clothes away from her and put her to bed, she stays there. That is one reason I put patients in the hospital.

The next reason is that I do not have time to visit patients at their homes, and I cannot see them as often as they need to be seen.

We must distinguish between pain and sensitiveness. Does that knee hurt you at all?

Patient: No.

Dr. Porter: Would it hurt if you moved it?

Patient: Yes.

Dr. Porter: Does it hurt you if you put your weight on it?

Patient: Yes.

Dr. Porter: That is sensitiveness. Pain is purely a subjective symptom in which we feel the joint ache, but sentitiveness is a pain that you can elicit by pinching or feeling of the joint or moving it.

If the joint is painful, hot fomentations are applied every two or three hours between 9 a. m. and 9 p. m. If the pain is severe, in addition to the fomentations a sedative lotion is used locally under the fomentations and separated therefrom by thin sheets of rubber dam or oiled silk. In addition, aspirin, sodium salicylate, or some of the more modern analgesics are sometimes used simply to help control the pain. In giving aspirin, the same amount of sodium bicarbonate is always given with it to avoid gastric irritation. When a joint presents any marked flexion deformity which cannot be overcome by any gentle manipulation, traction is used. In making traction to straighten out a flexed knee or hip, the leg must be elevated so the traction may be comfortable. If we were to put this man to bed, the first thing we would do would be to put on hot fomentations. If he had a painful joint we would put next to the skin a lotion. You may write your own prescription. I have used for years a combination of opium and lead water like the old-fashioned lead and opium, with an addition of extract of hamamelis or tincture of arnica. A cloth is saturated and put over the knee and a piece of rubber dam or oiled silk is put over that, and then a big, thick, voluminous dressing is put over the knee from above below and that is surrounded with either paper or with heavy sheet rubber to keep the bedclothes from getting wet and to keep the heat in.

As soon as the sensitiveness and pain have subsided, the knee is lifted up on an inclined plane. We build up a support in bed with the patient lying down. If you put on a traction and leave the heel resting on the bed, you are wasting time. The friction of the heel on the bed interferes with the pull of the traction and hurts the patient. Don't make the support of pillows because that doesn't last five minutes. Make it of something substantial; either get a good, solid box, or build up layers of one-inch board and tack them together with cleats; put a pillow on top of the support, put your adhesive plaster on from the end of the tibia to below the foot, put in a spreader so the adhesive plaster will not rub, put the pulley at the foot of the bed, put as much weight on as is comfortable for the patient. I am frequently asked

how much weight I use. That depends upon the knee and the patient's susceptibility. We put on all the pull that he can stand and be comfortable. When he says he is uncomfortable, we reduce the pull.

The object of the traction is not to separate the joint surfaces, because you cannot do that. The object of the traction is to relax these muscles which have been contracting for months and months, and even now when I attempt to straighten the knee out I can feel the contracted hamstring tendons on each side of the popliteal space.

If you put this leg up in traction and lift the foot of the bed about six inches so that the patient won't be sliding down all the time, in about forty-eight hours you will find that you can take out one or two of the boards underneath and let it down a little more, and the next day you can let it down a little more.

In a case with a history like this, that is put to bed with a knee flexed at right angles, we expect to straighten it out gradually with traction and do it perfectly comfortably in less than a week. If he had had a longer history it would take longer to straighten it out. The more acute it is, the easier it is to straighten it out.

The same is true in traction of the hip. If the hip is involved and the patient comes in with it flexed, we lift the leg up on an inclined plane until we have accommodated the angle of flexion.

In persistent sciatica which is caused by the pressure upon the nerve of an exudate around the joint (and, by the way, we see a lot of hypertrophic type of cases involving the lumbar spine and the sacroiliac joint), one of the first things the patient complains about is pain in the sciatic nerve or one of the nerves taking origin in the lumbar plexus. I know of no treatment which will relieve the patient so quickly as traction on the whole leg from the perineum down, with the leg slightly elevated.

Sometimes we see cases with the same disease in the shoulder, and they carry the arm to the side until it is difficult for them to abduct the arm, and you cannot abduct it to a right angle. We put the patient to bed; that does away with the action of gravity, and when we get the patient to bed we fold a towel around the arm, put it up on an inclined plane with the patient lying down, put traction on, and bring the arm up as high as we can and carry the weight over a pulley at the head of the bed. You will find the patient's arm will slowly go up in that way.

When the sensitiveness and pain have disappeared and the joint has been straightened out, then we immobilize the joint. For the immobilization of all joints I use plaster of Paris because I know of no way that a joint or a spine can be immobilized so quickly, efficiently and so comfortably as with a plaster of Paris cast. You know the old saying about the workman using a tool that he can use best. I have used plaster of Paris for thirty years, and I have a sort of feeling that I can put on a plaster of Paris cast that will hold a joint still and be perfectly comfortable. I spent several weeks with Sir Robert Jones in Liverpool. He sees more of these cases than any one man in America, and I did not see five pounds of plaster of Paris used while I was there, and that which was used I used for him. He immobilizes all of his joints with splints. He is as skillful in the use of splints as I am in the use of plaster of Paris. He uses what he can use best, and so do I.

After the cast is put on the patient is allowed to be up, but always on crutches if the joint of locomotion is involved and if the spine is involved. The first cast is kept on from four to eight weeks. In cases of the infectious type, the first group, if the joint is free from all pain and slight motion can be secured without pain, the cast is left off and physiotherapeutic measures are instituted to save the motion in the joint.

In cases of the proliferative or the atrophic type, the cast is converted into a removable splint, such as this case. If it is a knee, we split the cast up the front and put on straps and buckles so we can take the cast off and put it on, or else we make a new one with straps and buckles so the cast may be taken off for a half hour or an hour for bathing and physiotherapy.

If there is any motion whatever in the joint so that physiotherapy, massage, passive movement may be gently and gradually instituted, that is done, otherwise the joint will become stiff. These atrophic cases have to have movement early if you are going to save the joint.

In cases of the hypertrophic or the degenerative type, the cast is left on indefinitely, at least until all symptoms, including the hard, dense exudate, have disappeared, because if motion is instituted pain and tenderness are sure to continue and the joint rarely ever becomes stiff, even with immobilization, although motion may be limited.

In these cases it becomes a matter of choice of the lesser of two evils, as these joints will not recover as long as any motion is permitted.

DIRECT MEDICATION

I still believe we have no effect upon the disease except to relieve pain, and as I said a minute ago, aspirin, ten grains, with the same amount of bicarbonate of soda, will usually control pain in these painful cases.

I ought to say something about the injection of protein, foreign protein, into the blood stream. By the way, this patient has had three injections. He has had two or three injections of foreign protein. I don't know what was used. I wish Dr. Joseph Miller, who spoke to you yesterday, were here, because he has had a wonderful experience in the use of foreign proteins intravenously. He uses by choice dead typhoid bacilli. We have tried milk. We have tried nearly all the foreign proteins one after another in intravenous injections, but dead tubercle bacilli are as good as anything, and I think safer than milk.

Dr. Joseph Miller has had a long series of cases under his observation in the last four or five years, and he says that it is useless to use it in the chronic types in which the joints have become crippled. He says that there are a certain number of cases that will be permanently benefited and that number is large enough so that we are justified in continuing to use it, and I think he is right. He says that you cannot tell beforehand whether

your case will be benefited one particle or not, but that it is safe enough so we are justified in trying it out.

Furthermore, he says that the cases which offer the best prognosis are those in which the disease is subacute, in which the joint is not acutely inflamed and very sensitive, or in which the disease has not become chronic and the sensitiveness and pain have practically subsided. It is in the early cases after the acute symptoms have subsided that the injection of foreign protein is of greatest use.

SURGERY

First is the removal of the demonstrated foci of infection. I have told you that we have seen patients with all imaginable foci removed but still retaining their painful joints. I have seen a good many cases that have gotten well with the removal of a badly infected tonsil or prostate or gall bladder or teeth that were so badly infected that they could not be treated any other way. Don't misunderstand me. It is a useful thing. Every case that we put in the hospital we put through a thorough course of investigation for foci of infection, but you don't find them in a good many cases, and unless the patient's joint is immobilized and treated along some such line as I have suggested, he is going to continue to have his painful joint.

A great deal might be said about physiotherapy, but much that is said is indefinite and theoretical, and I only propose to make a few definite statements in regard to the methods in our use. Massage is of value. Massage, gentle massage, after all sensitiveness, swelling and pain and so forth have subsided and we are ready to leave off the immobilizing apparatus, is of great help. I would depend upon it more than any other of the physiotherapeutic measures. Passive movements must be very gentle. No forcible attempt should be made to move a joint which causes severe pain. If we were to send this man to a physiotherapeutic laboratory and following his massage somebody got hold and tried to bend the knee and increase the motion, he would have trouble and his pain and sensitiveness would continue. No manipulation which causes pain is of value; it is harmful.

Diathermy has been advocated as being of great value. I find it relieves the pain and sensitiveness. These cases of the atrophic group almost invariably tell you that their joints are made good by the use of diathermy, but the hypertrophic group certainly are benefited so far as the pain and sensitiveness are concerned. Whether it has any other value in the way of stimulating absorption of the exudate I do not know.

While the use of the alpine and other forms of mercury lamps is of doubtful value, I believe that sun baths are of great benefit. For that reason we have all cases treated with daily sun exposure in addition to the rest and physiotherapy.

At the Evanston Hospital, while we have a very well equipped physiotherapeutic laboratory, if the patient can go out on the roof and have sun exposures we send him out, otherwise we send him down to the laboratory and give him exposures with the alpine lamp.

I have no vote for or against the use of the mercury lamp. Those who have had much more experience than I must determine whether it is of value or not. Sun baths, and especially in patients of blond complexion, should be begun very gradually, exposing only a small portion of the body for a short time each day, and gradually increasing the area exposed and the time of exposure.

During the last two years the German literature has contained quite a good many very encouraging reports of the use of mirion in chronic arthritis. This is a new organic compound of iodin, the formula of which has not been published. I hope Dr. Young will tell us if he knows anything about the iodin compound of which I speak. It is a proprietary remedy known as mirion. I have used it, in one case especially with an extensive multiple arthritis of the atrophic type, in which I think there was benefit, especially in the relief of pain. I have not seen any evidence that it was of any further value. I don't know why it should be any better than any of the other iodin preparations. We have used iodin for many years with the idea that it stimulated absorption of the exudate. We have no definite proof, but we keep on using it.

Thyroid substances in small doses seem to be of distinct value in cases of atrophic arthritis. Swaim, who has observed a large number of these cases and studied them thoroughly during the past ten years, is so much impressed with its value that he prescribes it in all cases where the metabolic index is low. I believe its use should always be controlled by the metabolic index. I begin with one-eighth of a grain twice a day where the metabolic index is below plus six, and gradually increase the dose until one-fourth of a grain three times a day is given, and I believe larger doses than that are unnecessary.

In patients with a high general acidity, hot baths are of decided value and can be used once a day over quite a long period without detriment, but the baths should not last over twenty minutes.

I apologize for the length of time I have taken.

(See Page 350 for discussion.)

PULMONARY TUBERCULOSIS

Some of the facts brought out by the group of cases reported by S. W. Schaefer, Colorado Springs (*Journal A. M. A.*, June 18, 1927), are: Tuberculous lesions in the lungs do heal by absorption of infiltrations as well as by scar tissue formation. Tuberculous cavities in the lung do become very much smaller with improvement, and in some cases they apparently entirely disappear as far as the physical observations and the roentgen-ray examination can show. Artificial pneumothorax is often of great aid even in cases of pronounced bilateral tuberculous disease. If the body is relieved of the tremendous poisoning from a massive lesion in one lung, it may be able to cope successfuly with a smaller lesion in the other. Most tuberculous patients are apparently helped by a high, dry, sunny climate such as that in Colorado, and in some cases such a climate may be the deciding factor in the recovery of the patient.

The Use of O-Iodoxybenzoic Acid in the Treatment of Chronic Arthritis*

By A. G. YOUNG, M. D.,
Ann Arbor, Michigan.

I wish to express my appreciation of the honor that has been conferred upon me by asking me to speak before this Society. I am also glad to say that the work which I have to report here was started in Madison. The inspiration was obtained from the lectures given by Dr. Loevenhart when I was a student here, and also from some personal communications which he gave to me in regard to some of his experience with this drug. I believe he was the first man who used it in human beings.

I am also glad to say that members of the Jackson Clinic, Drs. Marsh and Cooksey, turned the first cases to me and collaborated with me in treating these cases. Later when I went to Ann Arbor, Dr. John Youmans of the Department of Medicine, generously offered to collaborate with me there, and we have treated most of our cases at Ann Arbor in the past two years. The sodium salt was used first because the acid is not soluble, but later we found the ammonium salt more desirable in that it was not so prone to produce thrombosis at the site of injection.

My first idea in regard to this compound was its possible value in the treatment of asthma. Since its action prevents the formation of edema, it might be of value in clearing up the edema which is supposed to exist in the lungs at the time of an asthmatic attack. I am sorry to say that I have not had any success with the few cases treated.

I also thought at that time, (and I am not convinced to the contrary yet) that arthritis is a symptom complex which may be associated with many of the same conditions which produce asthma, and for that reason I turned to arthritis when the treatment of asthma did not prove to be successful.

TREATMENT OF INFECTIOUS ARTHRITIS

O-Iodoxoybenzoic acid and its precursors O-Iod and O-Iodosobenzoic acid where first described by Meyer and his co-workers in 1892. The action of these substances was first investigated in 1899, by Heinz who attempted to study the action of nascent iodin in the body by their use. Loevenhart and Grove discussed the preparation and modification of these preparations and studied the effect of sodium iodoxy-benzoate on the blood. They found only slight changes following its intravenous administration, marked by a mild polymorphonuclear leukocytosis. Grove and Loevenhart studied the effect of sodium iodoso and sodium iodoxybenzoate on the respiratory center and concluded that the apnea produced by these compounds was due to the presence of the oxygen combined with the iodin. They also studied the antagonism between sodium iodoso-benzoate and hydrocyanic acid in regard to the respiratory center.

Arkin studied the germicidal action of the compounds and found that they had a high germicidal action against the staphylococci. Hektoen found that dogs given intravenous injections of sodium iodoxybenzoate produced more antibodies than the control animals. Amberg and Knox studied the action of sodium iodoxybenzoate on the local allergic reaction and found that it diminished the intensity of the intracutaneous reaction when given intravenously in rabbits, while iodbenzoic acid does not influence the process. They concluded that its effect was on the inflammatory reaction itself and that the oxygen is responsible for this action.

Arkin showed that sodium iodoxybenzoate when mixed with human serum, in vitro, markedly stimulated the phagocytosis of streptococcus and staphylococcus by human leukocytes. He also demonstrated that sodium iodoxybenzoate stimulated the production of hemolysin and agglutinin in rabbits when injected intravenously shortly after immunization.

Loevenhart and Eyster studied the effects of sodium iodoso and sodium iodoxybenzoate on the isolated mammalian heart. They found a marked increase in amplitude after the first administration, followed by a decreased amplitude.

TOXICITY AND PATHOLOGY

From the animal experiments carried on in this laboratory, we have concluded that the toxicity of the drug is determined by the rate of injection rather than by the quantity of the drug given. Thus a rapid intravenous injection of 0.3 grams in five per cent solution will usually kill a rabbit, while one gram may be given slowly without caus-

*Presented before the 85th Anniversary Meeting, State Medical Society of Wisconsin, Madison, September, 1926.

ing death. Repeated injections of the drug do not produce gross microscopical lesions in any of the organs. However, following a single large dose given rapidly, there is a slight congestion at the base of the lungs. The question of the mechanism of death, the cause of the apnea, and fall in blood pressure is discussed by Loevenhart and Grove. They conclude that since iodbenzoic acid does not produce these conditions, the oxygen combined with the iodin is the responsible factor. However, we feel sure that it cannot be explained on the basis of the oxygen acting as O_2 since an insufficient amount of oxygen is given to produce such results, and we believe the R-IO or IO_2 molecule must be responsible for these differences.

The drug is irritant to the tissues but does not produce a slough. It is antiseptic and irritant when sprayed on the mucous membranes, in 20% M solution. It was found to be quite efficient when applied locally in Vincent's angina and trench mouth, but is not superior to the ordinary oxidizing agents used in the routine treatment of these conditions.

Over fifty cases of arthritis have been treated. The results obtained in forty-three cases are reported here. All but two were chronic cases of two to twelve years duration. Two were subacute. Nearly all of the cases were of the atrophic variety. A few showed hypertrophic changes and two or three were probably gonorrheal. On the basis of clinical findings we have classified our cases as follows:

1. Subacute ..... 2 cases.
2. Cases with fixation, ankylosis, contractures, etc.
   (a) Cases with mild fixation, ankylosis, contractures, etc.
   (b) Cases with marked fixation, ankylosis, contractures, etc.

Our cases were not selected. We have taken anything that appeared to come under the head of infectious arthritis, whether of known or unknown etiology. In all cases with the possible exception of one the etiology has been unknown. We have taken arthritis deformans as well as Still's disease. We have treated but one case of the hypertrophic type, so that the atrophic, acute and chronic cases (with Still's disease considered under the head of chronic infectious arthritis) are what we have to report.

In our first report we cited forty-three cases which had been observed long enough to warrant a decision. Those cases had been observed for a period of three months to three years. At present we have treated over 100 cases at Ann Arbor, and I also have a report from Boston City Hospital where they have treated numerous cases of acute arthritis with favorable results.

As the patients came to us they were studied from every clinical standpoint. They were subjected to the laboratory examination, the roentgenological examination, and referred to otology and oral surgery for possible foci of infection. If such foci existed no drug treatment was started until they had been removed and the patient observed for a period of time sufficient to evaluate the results of these measures. Most of the cases were chronic, varying in duration from six months to eighteen or twenty years; all foci of infection had been removed as well as all possible foci of infection.

Many had been treated by other methods, such as foreign protein therapy, salicylates and orthopedic procedures.

The patients were hospitalized, confined to bed, but allowed to move about largely as they pleased in the wards. All other drugs were stopped at this time with the possible exception of analgesics for the relief of pain. In the old, chronic cases with pronounced physical deformity orthopedic procedures were used after treatment had been stopped; in other words, we gave the patient a course of treatment, then after he had rested for some time, if another course of treatment was deemed necessary that was given. Orthopedic procedures were then used to straighten joints which were being held in position due to the contraction of the muscles, and at certain times operation was necessary to remove definite blocks within the joint cavity itself.

PREPARATION OF DRUG

The drug is prepared as follows: one gram is considered a dose. When the acid is being used, it is neutralized by the addition of ammonium hydroxid. The drug is placed in a beaker and sterile distilled water is poured on it. The ammonium hydroxid is added until the drug goes into solution and is faintly alkaline to litmus. One hundred cubic centimeters of a one per cent solution is given by the gravity method and should require not less than seven minutes.

The drug must not be allowed to stand after it has been prepared. At present a stable ammonium

salt has been made which requires no neutralization but it should not be put into solution until the patient is ready for treatment. If the drug stands for three or four hours or more, it is very likely to lose its therapeutic value. What changes take place I do not know. We have not had an opportunity to study that yet.

The reaction, in regard to the patient is next to be considered. The patient first complains of a stinging, burning sensation in the mucosa of the mouth and the nose, and perhaps will say that his eyes burn. He may sneeze. If the patient has a tendency toward hysteria there will probably be some nervous manifestations. Children are very prone to become nauseated and vomit. Many of the adults complain of nausea, but very few vomit. There is a certain psychical factor, but that is not the entire explanation. The drug does produce a burning sensation in the epigastrium which may produce nausea in some patients. There is a great individual variation regarding the complaint at the time of administration of the drug.

Anywhere from fifteen minutes to two hours or perhaps three hours after the administration of the drug, (especially if the patient is running a fever at that time,) there will probably be a chill and an elevation of the temperature. These chills sometimes are quite severe. Joints will shake which have not been moved for some time, and that adds to the discomfort of the patient. It does not last long, and is usually followed by a period of rest in which the patient feels free from pain for the time and usually sleeps better.

The untoward reactions consist largely in thrombosis of the vein at the site of injection. That, again, is a personal factor; some patients have taken from eight to sixteen injections in the same vein, while in others we have had to seek a new vein for each injection.

We have used the same technique as nearly as possible, yet this variation occurs. I believe the drug is somewhat of an irritant at the site of injection, but I also believe there is an individual predisposition to thrombosis.

One other thing that has been noticed only occasionally but enough to be worthy of attention is that in two cases that we have treated, and one reported to us by Dr. Millard Smith, of the Boston City Hospital, an urticarial rash occurred after perhaps the third or fourth injection. In our cases it was not severe. It could be seen over the chest and the back, and lasted but a few hours. I do not know what significance to attach to it, but possibly it is of interest from the standpoint of explaining the action of the drug, which cannot be explained without further study.

Eight doses given at bi-weekly intervals are considered a course of treatment. The condition of the patient, the duration of the disease, and the extent to which it has progressed, will determine whether or not a second course of treatment is necessary. It is well to give the patient a rest for from one week to perhaps a month, (depending upon his condition) following a single course of injections before the second course of treatment is started.

There are a number of things to be gained by this. One is that the thrombosis in the veins will have had time to disappear and perhaps the same veins can be used again. Also the patient will probably notice some improvement during that time and will feel encouraged to undergo a second course of treatment.

At present I do not want to leave the impression that one should stop baking and massage and such other methods as might be of benefit to the patient at the time that you are treating him. We did this because of the experimental value of such procedures, but anything that will relieve the pain, and increase the circulation of the parts, should be done while drug treatment is going on.

I do not believe that any joint should be subjected to orthopedic prodecures while it is showing an inflammatory reaction.

SUMMARY OF RESULTS

A general summary of the results of the treatment shows that of the forty-three patients treated, twenty-four, or fifty-six per cent, were markedly improved; ten, or twenty-three per cent, moderately improved; six, or fourteen per cent, slightly improved; and three, or seven per cent, showed no improvement. These were chronic cases, with the exception of two. Improvement is taken to mean a loss or diminution of pain, a loss or decrease in the swelling, an increase in range of motion, loss of stiffness, increase in function of the joints, and an improvement in the general health as manifested by a disappearance of fever, gain in weight, appetite, color, strength and general well being.

"In judging the improvement that has been gained, one must take into consideration the condition of the patient at the time of entrance to the

hospital. For instance, several of our patients at the time of admission were helpless cripples, they could not feed themselves, and some showed such involvement of the temporomaxillary joint that they were unable to take food. Many were unable to walk and suffered from severe pain. In such cases the relief of pain, the regaining of sufficient motion of the joints of the hands, elbows and shoulders so they could feed themselves and sufficient improvement in the lower extremities so they could walk with crutches is considered vast improvement for the individual patient.

It is evident, therefore, that the degree of improvement reported must necessarily be a personal factor with each patient.

"A more detailed consideration of the various groups shows that of the four patients with the acute or sub-acute form of the disease, all showed marked improvement or complete recovery.

"Among the chronic cases, one patient had had the disease for from six months to a year, and he showed moderate improvement. Of nine who had had the disease from one to two years, seven were markedly improved, one slightly improved, and one showed no improvement. Of nine patients with duration of the disease from two to five years, six showed marked improvement, two moderate improvement, and one slight improvement. Of nine patients with a duration of five to ten years, five markedly improved, two moderately improved, and two slightly improved. Of eleven patients with a duration of over ten years, two showed marked improvement, five moderate, two slight and two no improvement.

"Of the men, twenty, or eighty-three per cent, showed moderate to marked improvement and four, or sixteen per cent, slight or no improvement. Of the women, fourteen, or seventy-three per cent, showed moderate to marked improvement, and five, or twenty-six per cent, slight or no improvement."

You can readily see that the age of the patient is not a deciding factor. One of the best responses we received was in a woman fifty-nine years of age.

Sex, I believe, plays no part in regard to improvement. Duration of the disease is not of so much importance as the deformity which has occurred. It is obvious that patients with very severe deformity of long duration will not show the response that would occur in an early case.

ACTIVITY OF THE DISEASE

Those patients in whom the disease appeared to be active at the time treatment was started showed a better response than those in whom activity was not noticeable. I believe that may be explained by the fact that those patients showing no sign of activity are suffering as much from the physical disability which has occurred as a result of the disease, as from any process of active infection at the present time. I do not want to discuss the hypertrophic type since we have had very little experience in this field, but I will say that we do believe we can stop the progress of the disease in a hypertrophic case. Certainly we could not expect to dissolve bony tissue. The deformity in the atrophic cases depends largely upon the individual. A great many of them who had not had the disease over a long period of time showed more atrophy and deformity than some who had had it for perhaps ten years.

Our results show that the most important factor in influencing the effect of the treatment lies in the degree of the anatomic deformity, crippling, and loss of function. It is in this group with the most marked changes, that the greatest number of failures occurred.

Obviously the acute cases show a quicker response and better improvement than the old chronic ones. Therefore, I believe the drug will be of real value from a preventive standpoint. I also wish to emphasize that the patient should have rest, (if possible, should be hospitalized,) and that you must use orthopedic measures to overcome crippling. Remember, too, that this drug must not be boiled and must not stand too long before using.

RHEUMATIC INFECTIONS

I have treated only a few cases, but the results appear to be encouraging especially in some cases of rheumatic heart infections who were apparently moribund at the time treatment was started. The drug does keep the fever down to practically normal, it slows up the heart rate, which goes far above what it should in comparison to the fever, and in that way it may save the heart or combat the infection (if rheumatic fever is due to an infectious process.)

In closing let me say that the iodin in this compound is not the active factor so far as we know. We think it may have some influence on the oxygen, but certainly the oxygen is one of the most

important parts of the compound. I think perhaps the way it is linked with the iodin is important, also.

Discussion

DR. F. A. CHANDLER (Chicago): The hour is getting late, and I will confine the few minutes I have to a demonstration of some of the cases of low back strain which have not yielded to relief or have not been relieved by the different procedures mentioned with the exception of arthrodesis. These cases have had backaches ranging from five to twenty years. They have been treated by plaster casts, by splints, braces, strapping, and every known means, including lying in bed for years. Some of these cases are private cases, some are hospital cases, and I have now the good fortune to show one case which has come under my observation following supervision by Dr. Hibbs of New York.

This is an x-ray of the kind which Dr. Smith so well described and to which more and more attention is being directed as a cause of a good many of these backaches. The large mass to the left of the picture is the sacralized fifth lumbar vertebra which in this case is fairly well fused.

This specimen I found in the anatomical laboratory, dissected the pelvis, disarticulated it, and these black marks show the articular surface of the sacro-iliac joints. A large mass can be easily seen to the left. On pressure from a superimposed spine, great leverage to the side can be demonstrated. It was demonstrated before the ligaments and fascial attachments were removed. This kind of spine is a very susceptible spine to strain; it is the vulnerable spot. The individual may go through life without any symptoms. On the other hand, the slightest trauma may create almost incurable conditions. Casts and braces worn over a period of years are probably worse than the disease.

We attack this type of case by the arthrodesis method which Dr. Schumm has mentioned.

This is one of our technicians in the x-ray department. She has complained for years of a weak back. Her back became so susceptible to strain that during activity in the x-ray room this girl had to give up about two o'clock in the afternoon every day.

This shows complete sclerosis along both sacro-iliac joints, indicating that besides a lateral leverage we have an irritation of some sort or other in the sacro-iliac joint. This case has not come to operation as yet. She is tolerating the condition as it is at present.

This girl has the same sacralized fifth lumbar vertebra on one side. She is at present convalescing from her operative procedure.

On exploration of these backs it has been very instructive to find the great amount of flexibility present at the lumbosacral juncture. It cannot be demonstrated except in a few cases by the x-ray of the spine in the weight-bearing and non-weight-bearing portion. In this particular spine not only was motion discovered to be excessive at the lumbosacral juncture, but motion above, between the two adjacent vertebrae, was found to be excessive.

Stability is not compatible with motion in that region of the body. The two lower vertebrae were fixed by an arthrodesis operation through the sacrum itself.

This man was sent to me hy Dr. Ryerson in Chicago, an ex-soldier who while in France was run over by a tank. Subsequent to that he had a painful back. There never was a fracture demonstrated. He was given treatment by casts, rest in bed, strapping, braces, and every known means of artificial external support. This is his post-operative picture. This large shadow in this area is new bone which has been thrown down from adjacent surfaces and is now fused into a large mass, transferring all functions which caused motion at the sacro-iliac joint to the next higher level.

This is the case operated on by Dr. Hibbs. This woman had been a very active athletic individual, used to mountain climbing, horseback riding, and so forth. Since early childhood this woman realized she had a weak back. She always found relief sitting on the floor with her knees curled up under her chin. When she had had a dinner party she found she was relieved only by sitting with one leg under the other, permitting lordosis to a more complete degree.

This woman last February was fused. I have had the occasion of following her since, and the recovery is remarkable. To talk with this individual and see her activity at present, as compared with the two preceding years, is a revelation. There is no doubt that she has a better mechanical area in this back.

This is another back, with the exception that instead of the sacralized fifth lumbar vertebra we have spina bifida occulta. This is a pre-operative picture, showing the long gap which the posterior ligaments must take at the lumbosacral juncture. In this individual there was also noted sclerosis of the sacro-iliac joints. She had been put in casts and had been wearing braces. There were two factors which I could not differentiate one from the other, and none of our consultants could. In this individual a spine fusion operation was done between the last lumbar and sacral and an extra articular fusion of both sacro-iliac joints, through a method which has not yet been published. The relief has been complete. I believe it is of long enough duration to warrant a definite statement to that effect.

This is another individual of the same type with a sacralized fifth lumbar fusion.

This is a scoliosis producing the same mechanical disability at the lumbosacral juncture. This man had scoliosis for years under treatment of one of our orthopedic men twenty years ago. Three years ago, while playing golf, something gave way in his back which was not relieved by braces or casts. A fusion was done, with resulting relief, merely transferring the function from the lumbosacral joint to the next higher level.

DR. R. S. CRON (Milwaukee): Obstetrical patients frequently have backache during the latter months of pregnancy. These patients carry their shoulders further backward so as to compensate for the enlargement in the abdomen, and as a result put considerable strain on the muscles and ligaments of the back. This is likewise true in patients with pendulous abdomens or large abdominal tumors. Relief can be obtained by a properly fitting corset applied while the patient is in the reclining posture and snapped from below upwards.

Retrodisplacements of the uterus do cause backache but by no means do all retrodisplacements produce this symp-

tom. Twenty per cent of virgins have retroversions but it is rare for any of this group to complain of lumbar or sacral backache. Forty per cent of puerperal women have backache but only about half of these complain of this symptom.

Before one advises operation for the correction of a retrodisplacement, one should correct it bimanually and apply a properly fitting pessary. If the backache is then relieved one should feel free to advise operation. In this way one can rule out backache the result of lumbo-sacral or sacro-iliac disease.

Retroversion complicated by inflammatory lesions and backache accompanying such pathology is, of course, another question, and there about eighty per cent of the backaches will be relieved by the proper operation.

Backache due to endocervicitis or cervicitis is greatly benefited and frequently completely relieved by cauterization of the cervix. A small nasal tip cautery applied after a radial manner should be used.

Pelvic tumors produce backache only when they are large enough to cause pressure. The smaller ones I am sure very rarely produce this symptom.

Many of us have seen patients develop backache after vaginal operations. The legs were either suspended in stirrups or the knees had no rest with the result that the back may be strained. In a somewhat similar way sacro-iliac and lumbo-sacral backache may be produced by hyperflexion of the legs on the abdomen during the removal of the Kelly pad or sheets. Here one can prevent backache by a little care.

PHOSPHATURIA AS LOCAL PHENOMENON

In the study of phosphatic urine, Lichwitz and others have called attention to the fact that a lipoid colloid separates from the urine as the urine becomes the milky urine of phosphaturia. On the other hand, if urines containing phosphates approach the alkaline reaction, dibasic calcium phosphate, tribasic calcium phosphate and dibasic magnesium phosphate precipitate out and produce a phosphaturic turbidity. As certain diets (vegetable, fruit and alkali) produce an excess of phosphates in the urine, either one of the foregoing factors—perhaps all three—may be responsible, in a measure, for the phosphaturia. Observations by Edwin Beer, New York (*Journal A. M. A.*, May 21, 1927), would suggest that this change takes place in the urinary tract on the mucosa of the urethra or ureters and perhaps similarly in the bladder, and that apparently the process is an instantaneous one. The three cases reported serve as evidence in favor of this peripheral or local character of the phenomenon.

Usefulness of the X-Ray in Obstetrics*

By GENTZ PERRY, M. D.,
Kenosha.

I shall tell you as much of the practical usefulness of x-ray work in obstetrics as the short time at our disposal will permit. In doing this I also hope to make clear the main limitations of x-ray procedures in obstetrical diagnosis.

We shall not take up the subject of showing an enlarged or misplaced uterus by means of the pneumo-peritoneal methods because the time allotted to this paper will not permit us to consider any more than the more commonly needed facts on this subject. The new and very efficient method of showing the uterine cavity, patency of Fallopian tubes, etc., by means of lipiodol or iodized oil, be longs to the domain of gynecology rather than obstetrics.

The majority of women can go through the full term of pregnancy and parturition without having any x-ray examinations. However, there are many cases where a careful x-ray examination is necessary:

1. Medico-legal cases;
2. Where an absolute differential diagnosis between possible pregnancy and uterine or other tumors, or pathology, is to be established. (See Fig. I[3].);
3. All cases of multiple or supposed multiple pregnancies should be carefully x-rayed not only to establish an absolute diagnosis, but also that the obstetrician may better judge how to manage the deliveries. (See Fig. 1[3], also Fig. 2[1].);

Fig. I[3]. Obstetrician was in doubt on diagnosis; first views made showed but little and case was referred to Dr. Alexander for special study. His A. P. views showed but little, but lateral views showed definite case of twin pregnancy quite clearly, both heads presenting.

*Presented before the State Medical Society of Wisconsin, Madison, September, 1926.

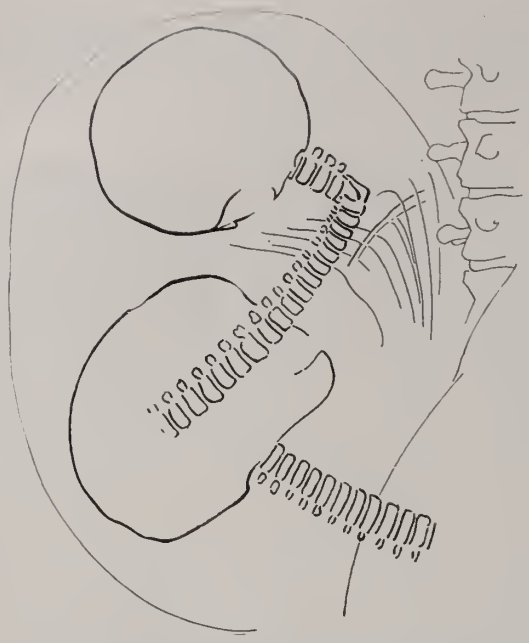

Fig. 2[1]. Live twins; apparent acute angulation of cervical spine (upper twin) suggesting the death of this twin. However, both twins were normally born, living, and appear to be normal in every way.

4. In all other cases where some abnormality is either known or suspected, a careful x-ray examination should be made. (See Fig. 3, Fig. 4[3], also Fig. 15[4].);

5. In cases of suspected fetal death we may use the x-ray views to assist in a possible differential diagnosis. However, as has been so carefully and thoroughly taught by Stein and Arens, the x-ray appearances are of very doubtful value in diagnosing fetal death. (See Figs. 2, 5, 6, 7, 8 and 9.)

Fig. 4[3]. This mother having carried child about 9½ months and the clinician not being able to determine position of child was referred for x-ray. X-ray views showed condition of anencephalus with breech presentation. A. P. and lat. views.

Fig. 3. Case of mother carrying fetus one month overtime. X-ray revealed case to be one of anencephalus. Fetus delivered by induced labor.

PREPARATION OF PATIENT

The patient should be carefully prepared for the x-ray examination by being kept upon a light diet for thirty-six hours prior to the examination and by having mild enemas at intervals of four or five hours apart, given so as not to disturb the uterine reflexes, until the alimentary tract is free from gas and as free as possible from fecal matter.

POSITIONS FOR MAKING FILMS

Usually the best position in which to place the patient for x-ray exposure to show earliest signs or appearances of pregnancy, is the horizontal, prone position, but with the patient's head and chest lower than her pelvis. In other words, have

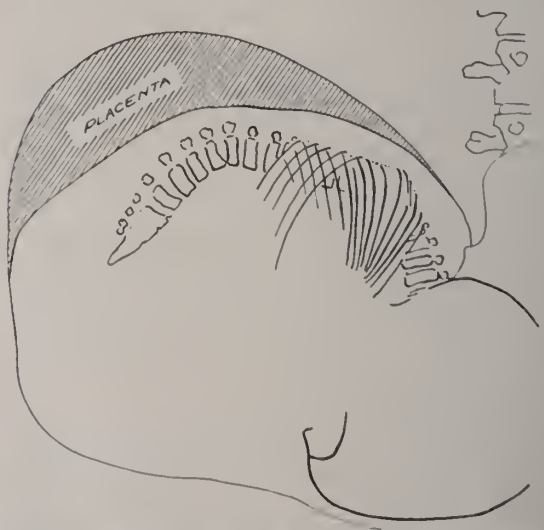

Fig. 5[1]. Lateral view; live fetus. Placental shadow on posterior wall near fundus. Apparent double acute angulation of spine.

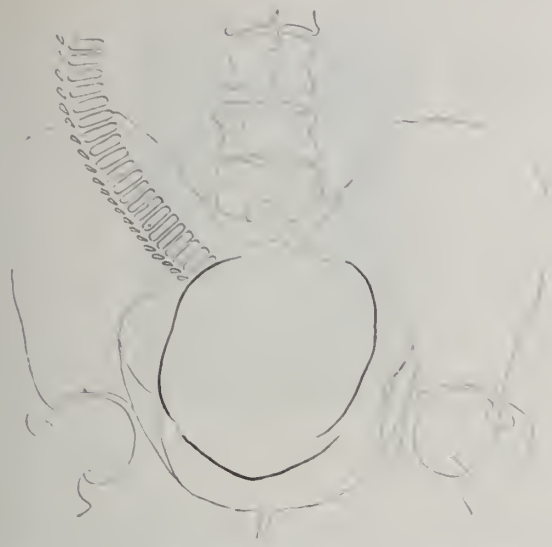

Fig. 6[1]. Live baby; well moulded head; first stage of labor; marked overlapping of cranial bones and asymmetry of head.

patient lie upon her stomach with head of table lowered several inches. For the x-ray exposure have the central ray directed from behind (or above) through the pelvis at a point just inferior to coccyx and angulated about 25 degrees from the direct postero-anterior diameter of the pelvis; this will direct your central ray towards the anterior superior brim of patient's pelvis.

As a routine examination of pregnancies of over five (5) months' development, there should always be two films made; one 14x17 film made in A-P position with patient lying supine upon the Bucky diaphragm and one 14x17 film made with patient lying on her side (most prominent side down) upon the Bucky diaphragm. (See Fig.

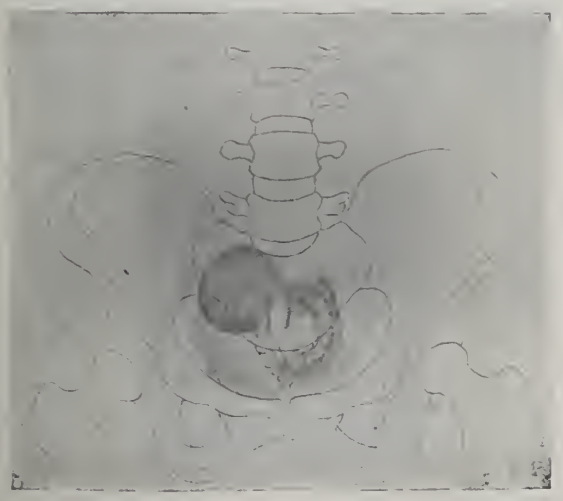

Fig. 7[1]. Dead five months fetus; acute angulation of vertebral column; no overlapping of head bones.

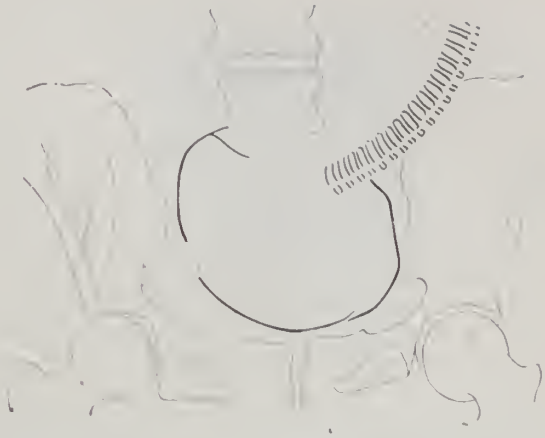

Fig. 8-A[1]. Fetus dead twenty-four hours; no overlapping of cranial bones.

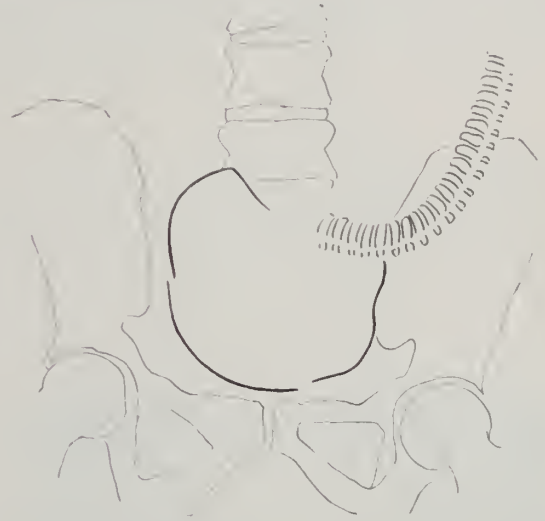

Fig. 8-B[1]. Fetus dead ninety-six hours; slight overlapping of bones of head.

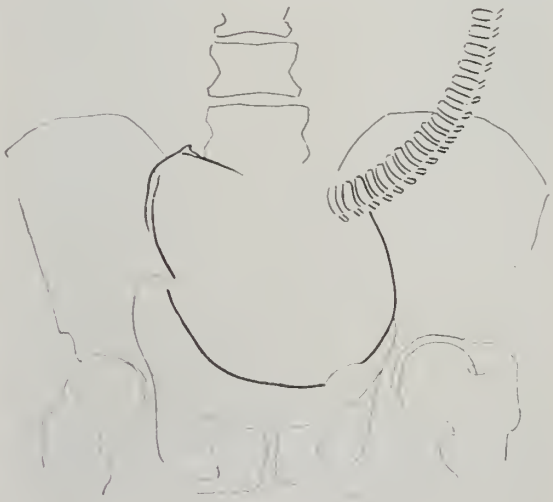

Fig. 8-C[1]. Fetus dead five days; shows typical overlapping of skull bones and asymmetry of head.

I[3].) In all of this work carefully placed markers should be placed so as to show exactly which is the right and which the left side of abdomen.

With proper technic, a pregnant woman can be given a thorough x-ray examination without any harm to either herself or the fetus, but it should be thoroughly understood that the x-ray has a powerful effect upon all living cells and that there is some danger to both the mother and fetus, especially to the fetus, if they are improperly exposed, or over-exposed to x-ray. Abortion may be caused by excessive x-ray exposures and fetal cataracts, and also fetal malformations, due to partially arrested development of the fetus, may be caused by excessive x-ray exposures, especially during the first three or four months of pregnancy. However, with proper technic two or even three x-ray examinations of the pregnant woman

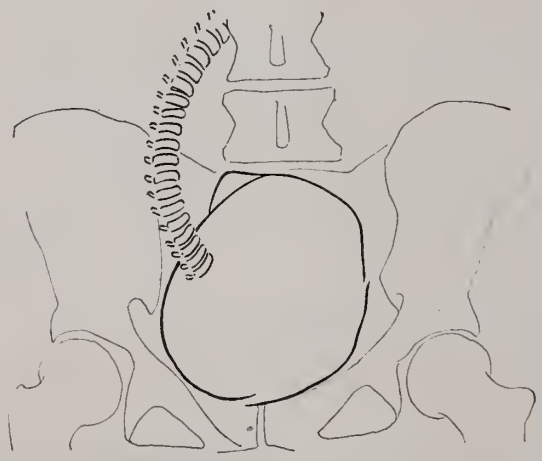

Fig. 9[1]. Live baby, post-mature; asymmetry and overlapping of head bones.

can be safely made. Allowing suitable intervals of time between them, more examinations could be made.

TECHNIC

The technic to be used in x-ray the pregnant woman will of course have to be varied to suit the size and physical condition of the woman to be x-rayed and the technic must also be modified or adapted to the particular x-ray equipment used.

A good Bucky diaphragm and first-class double intensifying screens 14 in.x17 in. in size, are necessary to do this work safely and successfully. While good views of the fetus in utero have been made without the use of the Bucky diaphragm, yet the percentage of failures to get diagnostic films of obstetrical cases without using the Bucky diaphragm is much greater. It is desirable to have

Fig. 10[3]. Shows normal 7 months' pregnancy with R. O. A. presentation.

all factors of equipment and technic as perfect as possible before attempting to x-ray a pregnant woman.

While various x-ray specialists report using voltages that vary all the way from 50 to 150 K. V. to get diagnostic obstetrical films, we have found, in our work, that a voltage represented by a point spark gap of 5 to 8 inches (depending upon the size and conditions of the patient) gives us the best results. For the average patient we use a 6-inch gap, which is represented on our machine by a meter reading of 110 K. V. while delivering 30 milliamperes to the tube, and an exposure time of from 4 to 7 seconds. One of our Bucky diaphragms is made for a target-film distance of 25 inches and our other Bucky diaphragm is made for a target-film distance of 27 inches. Of course, the exposure time is about one-sixth greater on the 27-inch distance. We use 8-inch cones.

Fig. 11. Shows normal 8 months' pregnancy with R. O. A. presentation.

Let us now consider the matter of filters: It is almost universally agreed that the main biological effects of x-ray occus where the x-ray or beam of x-ray stops in the tissues and is changed to heat and secondary radiation. So, in order to avoid, as far as possible, the damaging effects upon the skin of the mother and upon her ovaries and digestive tract, and also to do this x-ray work with the least possible effect upon the fetus, we use such filters as will best absorb the softer rays before they reach the patient. We use aluminum filters from 1 to 3 mm. thick for this purpose; usually one of 2 mm. in thickness. By stopping the softer rays before they reach the patient, these filters also prevent some of the secondary radiation that is so liable to cause fogging of the films and thus tend to obscure detail. Of course, if we use too much filter we shall lose

Fig. 12[3]. Twin pregnancy at 9 months; both heads presenting.

the necessary contrast on our films, but it is very difficult to make films of the pregnant woman so as to show a *deep contrast* without an undue amount of exposure to the patient.

Compare appearances of Figs. 10[3], 11, 12 and 14 with those showing pathology and anomalies.

In closing, let us again emphasize that x-ray examinations of the pregnant woman should never be undertaken by anyone except by the experienced radiologist.

Fig. 15[4]. Case of anencephalus discovered by x-ray examination because mother carried fetus three weeks beyond normal time for delivery.

The x-ray diagnosis of pregnancy and of complicating conditions and anomalies or of supposed pregnancy is, if properly done, a safe and valuable procedure.

REFERENCES

1. I wish to gratefully acknowledge my indebtedness to Drs. Stein and Arens of The Michael Reese Hospital, Chicago, for the illustrations shown as Figs. 2, 5, 6, 7, 8 and 9. These cuts are reproductions of exact and careful tracings made from the original x-ray films by an experienced artist, and they are exact and faithful illustrations of the conditions found and explained by Drs. Stein and Arens.

2. I wish to also acknowledge my indebtedness to Mr. J. R. Bruce, Publisher of RADIOLOGY, for his generosity in furnishing some of the plates from which these prints are made.

3. Through courtesy of Dr. W. G. Alexander of Evanston, Illinois.

4. Through courtesy of Dr. B. C. Cushway of Chicago.

Fig. 14. A normal breech presentation at full term.

Certain Practical Phases of Cholecystography by the Oral Method*

By B. R. KIRKLIN, M. D.,
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Rochester, Minnesota.

Three years ago, a long step in advance was made in the diagnosis of cholecystic disease, when Graham and his coworkers found that certain halogen salts, if injected into the blood, were excreted in the bile, entered the gallbladder, and produced a visible shadow in the roentgenogram. This method was received with acclaim. Menees and Robinson conceived the idea of administering the bromine salt by mouth, and Whitaker tried out the iodine salt in the same way; other drugs were used and a voluminous literature testifies to the widespread application of cholecystography. I shall discuss the subject briefly from the standpoint of my personal experience, and without analysis of the comparative merits of drugs and technical methods.

At the Mayo Clinic, both sodium tetrabromphenolphthalein and sodium tetraiodophenolphthalein have been used extensively in cholecystography, chiefly by the oral method. Other drugs have occasionally been employed, and the method of intravenous administration has been given trial. At present the iodine salt is being given by mouth for routine examinations. Only a small dose of this salt is required, reactions are few and never grave, and an excellent shadow of the normal gallbladder is obtained. The dose of the iodine salt varies from 2.5 to 5 gm., depending on the weight of the patient. He receives the measured dose in plain gelatin capsules, each containing 0.5 gm. of the salt, and is instructed to take it immediately after the evening meal, which must be free from fats. Roentgenograms are made after fourteen, sixteen, and twenty hours. The patient may take water, but he must abstain from food until after the sixteenth hour, when he must eat a meal rich in fats. The object of this fatty meal is, of course, to stimulate emptying of the gallbladder.

A cholecystogram indicating a normal gallbladder is dependent on the following well-known factors: (1) if the oral method is used, absorption of the drug from the intestinal tract; (2) excretion of the salt by the liver; (3) patency of the cystic duct; (4) a mechanism of resistance at the end of the common bile duct which causes the gallbladder to fill, and (5) ability of the mucosa of the gallbladder to concentrate the drug. The cholecystogram of the normal gallbladder should exhibit a good shadow of the gallbladder with even contour and homogeneous density. At the fourteenth and sixteenth hours the roentgenograms show some variation in the density and size of the shadow, especially change in size, which is indicative of elastic walls. Usually the density is greater at the sixteenth hour. After a meal rich in fats or egg yolk, such as that taken by the patient after the sixteenth hour, the viscus should be empty or markedly diminished in size. In the fasting state the size of the gallbladder varies considerably, and unless it is extremely large or not diminished after twenty hours, size may be ignored.

Abnormal responses to the test comprise absence of any shadow of the gallbladder, a faintness or unchanging size of the shadow at all periods, mottling of the shadow, and gross deformity of contour. Failure of the gallbladder to cast a shadow in any of the serial roentgenograms is the most common and perhaps the most reliable sign of disease. If the patient has taken the drug and has not vomited it and satisfactory roentgenograms have been made of the entire region of the gallbladder, a high degree of dependence may be placed on this sign. As a rule it indicates either that the drug has failed to enter the gallbladder or that the gallbladder has been unable to concentrate it sufficiently to produce a visible shadow; obstruction of the cystic duct and disease of the cystic wall are by far the most common causes. For the same reasons the shadow may be persistently faint, and this is also a valuable sign. The interpretation of a faint shadow is difficult as the personal equation enters into it and normal concentration has a rather wide latitude. With experience and careful checking, however, normal and abnormal densities can be distinguished. Mottling of the shadow may be caused by stones, or, occasionally, by papillomas. Stones with high calcium content produce localized areas of intensification of density within the shadow of the dye; such stones are also visible if none of the dye enters the gallbladder. Cholesterin stones are indi-

*Read at the Radiological Section meeting of the State Medical Society of Wisconsin at La Crosse, Wisconsin, May 14, 1927.

cated by areas of rarefaction mottling the shadow. Unchanging size of the shadow is an indication that the gallbladder lacks normal elasticity. If it remains constant in size and shape, even though of normal density, the patient should be examined again without dye, for the shadow may be cast solely by a diseased gallbladder and not by the dye. Gross deformity of contour, such as hourglass deformity or acute angulation, will occasionally be confirmed at operation. Irregularity of contour is not always indicative of adhesions, and dense adhesions may exist without deformity of the shadow.

In the present stage of cholecystography, errors, both of commission and omission, will occur, and some of them will perhaps always be inevitable. Aside from purely personal mistakes which cannot justly be charged to the method, the method itself is not infallible. Occasionally a gallbladder which casts only a faint shadow or none at all in the roentgenogram, is found normal at operation. In certain of these instances the drug may not have been absorbed from the intestine, although this is infrequent and the examiner is usually warned of it by the presence of diffuse shadows of dye in the bowel. In others hepatic insufficiency, as in extensive cirrhosis, may have been responsible, although a high degree of hepatic injury is necessary to affect the cholecystogram. Often in cases of duodenal ulcer the cholecystogram is positive for disease of a gallbladder which is found to be normal at exploration. Plummer has noted that a certain type of case, characterized by easy fatigability, achlorhydria and low basal metabolic rate, is likely to yield a positive cholecystogram, although there may be little, if any, clinical evidence of cholecystic disease. Mottling of the shadow by gas in the bowel may be misinterpreted as indicating cholesterin stones, but such areas of translucence are not likely to be present or identical on all films.

On the other hand, a markedly diseased gallbladder, even one containing stones, may appear quite normal in the cholecystogram. It is well known that a gallbladder containing stones may have fairly normal walls, and thus be able to perform its concentrating function. A shadow cast by a diseased gallbladder itself or by a calcified psoas abscess may be mistaken for a shadow cast by dye filling a normal gallbladder. Another source of error is the gallbladder which is not grossly abnormal and manifests only microscopic evidence of disease; a considerable number of such gallbladders respond normally to cholecystography.

In appraising the accuracy of cholecystography in diagnosis many factors are to be considered. First, there must be definite agreement as to what constitutes a diseased gallbladder. A gallbladder which seems to be normal on surgical exploration, may prove on microscopic examination to be markedly diseased; on the other hand, there is a point at which microscopic changes must become negligible.

Statistics on diagnostic accuracy may be compiled in various ways and with various results. At the Mayo Clinic, our own compilations indicate that cholecystography, although not errorless, is highly reliable. In a large series of cases cholecystographic diagnosis was positive in 98 per cent of the cases of stones, 79 per cent of the cases of marked disease of the gallbladder without stones, and 66 per cent of the cases in which there were only slight pathologic changes. In approximately 91 per cent of all the cases of cholecystic disease found at operation, cholecystographic data were positive while in only 75 per cent of the cases in which the gallbladders were normal at operation the response to cholecystography was normal.

In the foregoing series, 93 per cent of the positive cholecystographic diagnoses were confirmed at operation. On the other hand, only 69 per cent of the cases in which the response was normal were found to be normal at operation.

It must not be assumed that cholecystography will automatically disclose cholecystic disease, distinguish with precision between varieties, or invariably exclude it. Supine dependence on the roentgen ray for any diagnosis has always been its greatest handicap; however excellent roentgenography may become, it should not be expected to achieve perfection. Cholecystography is not entirely comparable to roentgenologic examination of the stomach with the opaque meal, by which gastric lesions are directly demonstrable. Barring the occasional revelation of stones, cholecystography does not portray specific disease of the gallbladder. Cholecystography is a test of function and thus an indirect method of examination. If the ability of the gallbladder to receive and concentrate bile is impaired, cholecystography will reveal the fact, which may be construed as an indication of organic disease. But occasionally, as has been pointed out, a diseased gallbladder may perform its functions properly and yield a normal

cholecystogram. Conversely, a gallbladder which is histologically normal may sometimes yield an abnormal cholecystogram, either from transitory functional disturbance at the time of examination, or from other causes. Hence a final diagnosis of disease of the gallbladder should rest on a correlation of all evidence obtainable. Despite its limitations, cholecystography is at this time undoubtedly the best method devised for roentgenologic examination of the gallbladder, and with increasing experience should give increasingly better results.

Both Bone Fractures of the Leg: The Importance of Preventing Backward Bowing

By F. C. HEIDNER, M. D.,
Milwaukee.

It is the purpose of this short paper to call attention to the importance of avoiding backward bowing of the leg in treating fractures of both bones. It is prompted by the fact that in the past three or four years many patients with both bone fractures have come to us for a final examination in which the failure to establish the normal mechanics of the extremity has prolonged the temporary disability and increased the amount of permanent disability. They are patients injured under the compensation act and are sent by insurance carriers before being taken before the Industrial Commission for final hearing and adjustment of the case.

The most common site of these fractures is at the junction of the lower and middle thirds of the shaft of the tibia because this is its thinnest and weakest point. The fibula usually is broken a little higher.

The cause is either direct or indirect violence and the fracture line most frequently runs from below obliquely upward and backward. The displacement of the lower fragment is upward, backward and outward, and is easily explained by briefly recalling the muscular attachments in this region. It is displaced upward and backward by the muscles of the calf pulling on the tendo-Achilles. It is displaced outward by the fact that the tendo-Achilles is attached to the outer side of the calcaneous and that the peroneii muscles on the outer side have no corresponding opponents on the inner side. The upper fragment is pulled forward by the quadriceps femoris. (Davis pp. 559.)

The weight bearing line normally runs slightly anterior to the middle of the ankle joint because of the anterior bowing of the tibia. (See Fig. No. 1.) When there is backward bowing, the lower end of this line moves backward and the weight of the body falls onto the heel. There is plantar flexion of the foot because the muscles of the calf are stretched over the bow and hence pull on the calcaneous through the tendo-Achilles to bring it up and the toes down. (See Fig. No. 2.) This

Fig. 1. Line A.-B. is normal weight bearing line.

Fig. 2. Line A.-C. is longer than line A.-B.

Case 4. A. L., 24 years. Compensation Case. Collected 5% permanent disability at ankle joint because of pain and inability to dorsally flex foot. Temporary disability six months. There is one-half inch shortening. Antero-posterior and lateral views.

gives rise to a great deal of pain at the ankle joint and interferes markedly with the function of the joint since the patient finds it difficult to bring the foot forward without the toes dragging.

The two most common methods of treatment in use are the circular plaster of Paris cast and the Jones splint. It is of prime importance to remember in the application of either of these methods that gravity plays an important role. It is common practice when applying either of these methods to have the patient lying on his back, the assistant elevating the limb by lifting the heel while the operator applies the apparatus. It is obvious that the combined effect of the upward traction on the heel and the downward pull of gravity on the bones of the leg will result in a backward bowing at the site of fracture. If now the patient were placed on his abdomen instead of on his back, the leg again elevated by traction on the foot, the same forces would work in the opposite direction causing a slight anterior bowing which is far preferable to the disastrous backward bow.

The use of skeletal traction with a Steinman pin, either through or just above[1] the oscalcis, beside incurring the added risk of producing osteomyelitis, does not in itself prevent backward bowing and plantar flexion of the foot. If there should be cause to resort to this elaborate method, the toes must be held up and a pad properly adjusted below the site of fracture. It is not necessary to obtain more than one-third apposition of the fragments if the proper alignment is maintained. (Case No. 4). The pelvis will compensate for shortening of the leg up to two centimeters.

It may be stated that the cases illustrated here were all closed fractures. They were all left with permanent disabilities ranging from 5% to 15% at the ankle joint. The disabilities were due solely to backward bowing which resulted from improper treatment.

Case No. 1—B. S. 9 years. Public Liability Case. Permanent disability estimated at 10% because of a painful ankle and toe drag, due to chronic plantar flexion of foot. Was allowed to walk eight weeks after injury.

Case No. 2—W. E. 59 years. Compensation Case. Collected 15% permanent disability at ankle joint because of painful ankle, inability to dorsally flex foot. Five and one-half months temporary disability.

Case No. 3—C. W. 34 years. Compensation Case. Collected 5% permanent disability at the ankle joint because of pain in ankle, lack of dorsal flexion and tiring on use.

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Case 5. H. L., 55 years. Compensation Case. Five percent permanent disability at ankle joint because of pain and inability to dorsally flex foot. Temporary disability six and one-half months.

THE JOURNAL CLINIC

Diagnostic Problems

By L. M. WARFIELD, M. D.,
Milwaukee

In the May Journal we had the problem of a girl, 6 years old, who fell on her back, later had pus in the urine and fever. Developed stiffness of the neck muscles and Kernig's sign.

DISCUSSION

After hearing the history of large amounts of pus in the urine with no casts and little or no albumin, it was quite evident that the child had acute pyelitis. She had had a mild pyelitis previously. The recurrence of this disease is very common and the symptoms of frequent urination, prostration and fever are concomitants of the disease. She was quite well before she had the fall on her spine. What was the connection between the fall and the pyelitis, and between the fall or the pyelitis and the meningeal symptoms?

The first thought which naturally came to mind was that the fall had activated a pyelitis which probably was never absolutely cured and that the meningeal symptoms were the result of tuberculous meningitis. Cerebro spinal meningitis, I considered, could be ruled out because of the gradual onset, the absence of headache, the absence of skin eruption and the generally bright appearance of the child. She did not look very ill. She looked tired and languid. Spinal puncture would help settle this question.

Did she have tuberculous meningitis? There was the mother with a history of probable Pott's disease. Here was an illness beginning with fever, then showing retraction of the neck and Kernig's sign with projectile vomiting on one occasion. There were features, however, which did not fit in well with that diagnosis. The onset was rather rapid, there had been no irritability, no night cries. There was no persistent vomiting, no headache. No one had ever noted any irregularity of the pulse and the pupils had always been equal. There were no evidences of stiffness in any group of muscles except the neck. The appearance of the child was certainly against this diagnosis, yet we know how many-sided the symptomatology of tuberculous meningitis can be. My guess was that we were dealing with a severe case of pyelitis with meningeal irritation, not inflammation. A lumbar puncture was then made. The fluid was under considerable pressure and was perfectly normal in appearance. This confirmed my opinion but left me hedging on the possibility that it *might* be tuberculous.

The examination of the fluid in a laboratory showed no pellicle or filmy clot formation, twenty cells to the cu. mm., Wassermann reaction negative, Gold Sol 0001222100, Ross-Jones and Noguchi globulin tests positive. Microscopic examination of the centrifuged sediment revealed no micro-organisms. Culture of the second specimen of spinal fluid showed Gram-positive diplococci.

Culture of the urine showed both colon bacilli and a staphylococcus albus (the latter possibly a contamination). No leucocyte count was made. The child was in its home. The day after I saw her the attending physician, at my suggestion, made another lumbar puncture. The fluid was perfectly clear and under no pressure.

The meningeal symptoms began to subside following the first puncture. Within a week the child was much improved, the meningeal symptoms had vanished and the pyelitis was lessening in severity. Word from the parents two weeks after I saw her was that she had recovered.

It would have been most comforting to have had a full blood count, a complete report on the spinal fluid, and the report of the bacteriological examination of the urine before expressing any opinion on the case. The important lesson here is that while these would have been helpful they were not necessary for a diagnosis. After the last two of these reports were known they only added confirmation to what was already known. The history, the physical examination and the macroscopic character of the spinal fluid made the diagnosis.

A NEW PROBLEM

A married woman, aged 35 was seen recently complaining of dizziness, pressure in the head,

pounding heart and constant feeling of weariness. There is nothing of importance in the family history. As a child she had measles and erysipelas, not a serious attack, and no scarlet fever. Her menstrual periods began at the age of 14. They were never very regular until a year or two after her child, now 11 years old, was born. This has been her only pregnancy. She has always worked hard during her life. Two years ago she complained of dizziness and a physician told her that she had high blood pressure. Her average weight is in the neighborhood of 140 pounds. She dieted at that time, then had an attack of grip and lost weight to 120 pounds. There has never been any blood in the urine, bowels have always been regular, appetite good. There is occasional nocturia. She has never had any eye troubles or any special nervous troubles.

During the summer of 1926, she worked very hard on the farm, and developed shortness of breath, dizziness, aching in the back of her head with a peculiar pressure sensation. All during the winter she found she had no endurance, she could do only light housework. During this period she was seen occasionally by a physician, who found that she always had a very high blood pressure.

On examination patient seemed quite weak, able to walk but with assistance. She was slender, had lost some weight but in general was fairly well nourished. There were scattered papules and pustules over her face and chest, due probably, to recently administered iodides. Her pupils were dilated, reacted normally. Her upper teeth were false and a few lowers were in fair condition. The tongue was slightly coated. There was a slight but definite thyroid enlargement but there was no thrill or bruit over it. There was no tremor of the extended fingers nor any eye signs. The heart and lungs showed nothing abnormal except that the heart apex beat was a little displaced in the 5th interspace 10 cm. from the midsternal line. There were no murmurs. The second aortic was accentuated. The blood pressure was 224/140, pulse from 100 to 108. Radial vessels were easily palpable and uniformly thickened. The abdomen was flat and nothing was found on palpation. The knee jerks were present. Vaginal examination was negative. With the fluoroscope it was seen that there was some left ventricular hypertrophy with no increase in the shadow of the aorta. Examination of the eye grounds with the ophthalmoscope showed perfectly clear discs somewhat paler than normal with the cupping present but not as distinct as it usually is. The vessels were not tortuous, there was no light streak and the veins were not compressed when crossed by arteries. There was no exudate anywhere. Lumbar puncture revealed a clear spinal fluid under slight pressure. About 40 c. c. were obtained. Neither the blood pressure nor the pulse rate were effected by the withdrawal of fluid. The urine was clear and occasionally showed a trace of albumin and a few hyaline and granular casts. The dilution and concentration test was normal, the P. S. P. was 45% in the first hour and 7% the second hour. The N. P. N. of the blood was 28.2 mgm. per 100 c. c. The basal metabolism first estimation was plus 34%, the second test, two days later, was plus 19%. X-ray pictures of the head showed no abnormal shadows and the sella turcica was normal.

The discussion of this case will be continued in the next month's Journal.

RELATIONS OF PHYSICIAN TO PUBLIC HEALTH

Hugh S. Cumming, Washington, D. C. (*Journal A. M. A.*, July 2, 1927), discusses the past and present relationship of public health and the medical profession; the development of health organizations, and of the medical profession and public health activities. He points out that it will be impossible for any group to delimit the respective fields of the private practitioner and the public health official in specific terms appropriate to the whole country. The people as a whole appreciate the value of and, in a large part, the method for obtaining health. They are naturally more or less indifferent as to how this end shall be accomplished. The medical profession must appreciate this fact and aid in working out a solution. It is the privilege of the profession to cooperate with the public and its duly appointed representatives in the development of a satisfactory system, and it would be unfortunate to give the public at large any impression to the contrary. From time immemorial the medical profession has been regarded as the natural sponsor not only of individual but also of community health. Legal provisions relating to standards of medical education and privilege of the practice of medicine rest on this foundation. Whether this service in future shall be rendered by the profession in cooperation with health authorities or be made incumbent on the legal health representatives must depend on the character of the service rendered by the profession. It should be the object of the organized profession to impress on each individual physician his responsibility in this matter.

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There is listed the following definite services that are available to our readers—the members of the State Medical Society of Wisconsin. If you have a need not covered here address the Secretary, Mr. J. G. Crownhart, 153 E. Wells Street, Milwaukee. "Let George do it."

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FOR THE COUNTY SOCIETY

1. *Program Material.* Pursuant to authorization by the 1924 House of Delegates the Secretary is arranging to make program material available without cost. The following can now be secured:

A. Departmental Officers of the State Board of Health. Address Dr. C. A. Harper, State Health Officer, State Capitol, Madison, Wis.

B. Clinicians of the Wisconsin Anti-Tuberculosis Association when in vicinity. Address Clinic Dept., W. A. T. A., 558 Jefferson Street, Milwaukee.

C. Councilors and Officers of the State Society. Address the individual.

2. *Annual Statements.* Uniform annual statements can be had without cost. Address the Secretary, advising number desired.

EDITORIALS

THE GOVERNOR'S VETO

AFTER passage in the Assembly, 86 to 3, and passage in the Senate, 23 to 7, Governor Zimmerman in June vetoed a bill to appropriate $10,000 over a two year period to rid Wisconsin of its major law violators in the field of treating the sick.

The veto came very much as a surprise. We believe that the message, printed elsewhere in this issue, indicates that the Governor did not understand the public health nature and importance of this measure. Under such conditions we suggest that the measure might well be represented at the next legislative session.

While the veto means present discontinuance of the special investigator employed on surplus funds, we hope it will not mean relaxation in the public spirited effort to protect the ignorant and credulous sick from those who seek to earn riches through fraud, deceit and quakery.

REAL GAINS

NEVER before in the more than twenty years which have elapsed since the first tuberculosis sanatorium was opened in Wisconsin has there been so little of a spring exodus of the patients as is shown in the present year. As a consequence, never before at this time of the year has it been so difficult to secure beds for tuberculosis patients. This in spite of the fact that during the past year, the accommodations have been increased by over 100 beds.

The lives of many of the sanatorium patients have been materially lengthened. This will account for a part of the present overcrowded conditions. But it is also reported from many of the institutions that more early and even non-bacilliary cases are being received. Which fact reflects credit upon the improved technique of the medical profession in discovering early cases. However, the fact that something like 85 per cent of all cases arrive at sanatoria throughout the country in advance stages of the disease, does not give us overmuch to crow about.

It must be conceded, however, by the critically minded that the standards of classification have been gradually raised during the past few years. Many cases which would have been classified as *incipient* a decade ago are today graded as *moderately advanced*. It would appear, therefore, that the *real* gains are somewhat greater than the *apparent*. That there is a concomitant improvement in the mental attitudes of prospective sanatorium patients and their relatives in respect to accepting the prescribed treatment is also certified to by many physicians. They require far less argument, suasion, and browbeating to prepare them for the sanatorium course. All of which reflects a very wholesome state of affairs and an endorsement of the patient and persistent campaign of education in which the medical profession has led off, and in which the lay public have proved to be reasonably apt pupils.

H. E. D.

THE COUNCIL ON PHYSICAL THERAPY

IT IS probable that the profession at large does not realize either the importance of the work undertaken by the new Council on Physical Therapy brought into being by a resolution of the House of Delegates of the American Medical Association at the Atlantic City session in 1925, or the magnitude of the undertaking.

The work of the Council involves, in the first place, a determination of the manner and extent to which various physiological as well as pathological states may be influenced by external physical agents and, in the second place, a decision as to the extent to which the various types of apparatus offered for sale to physicians are capable of bringing about the biological reactions which it is desired to obtain. In carrying on this work of investigation, the Council has enlisted the assistance of the Federal Bureau of Standards, thus assuring an impartial and thorough investigation of the basis of all physical therapy procedures and a correct evaluation of the types of apparatus offered. When the work of the Council has progressed to the point where definite reports can be made it will no longer be necessary for the physician to obtain his knowledge of physical therapy and physical therapy agents from high powered salesmen whose chief concern is the sale of apparatus with, in many cases, all too little regard to its reliability or adaptability to the purpose in hand. On the other hand, the manufacturers of

worthy apparatus will be the gainers also through such tacit endorsement as approval of the Council affords. *J. F. S.*

A WISE JUDGMENT

A JUDGMENT recently handed down in Ontario makes illegal in that province the use of the title "Doctor" by anyone who is not in possession of a proper medical degree. The judgment will be welcomed by all right thinking people, for no professional title has been more shamefully exploited by quacks and charlatans than that of Doctor. The genuine medical man who received his mandate to tend the sick only after spending years of his life in diligent and expensive study at college and university will welcome this blow dealt the unscrupulous individual who poses as a benefactor of mankind but who in reality is only a gambler in human lives. The longer the quack is allowed to fool the public by the use or rather abuse, of an honorable title to which he has no right in the world, the more daring does he become and his unhealthy tribe increase.

There is always to be found a class of people who take a special delight in rapping the genuine doctor at every opportunity. They regard the medical profession as a band of tyros who destroy more lives than they save and point to the quack with his few months of "training" as a modern marvel who cures every ill that flesh is heir to,—"in nature's way." It is surprising, too, how many misguided people "fall for" the quack and his bunkum.

Commenting on the attitude of the orthodox medical man towards the quack, Dr. Hoyt E. Dearholt of the Wisconsin Anti-Tuberculosis Association says: "Nobody is so well aware as physicians themselves of the shortcomings of this great profession. None so overwhelmed by appreciation of the difficulties of even the best of minds to acquire the vast amount of knowlege a really competent doctor should have. Such men are not "jealous of quacks" and other practitioners who treat the sick after but a few months of alleged study. Their impatience and disgust are not aroused by personal jealousy, in the ordinary sense of the word, but by a "heartsickness" that supposedly intelligent neighbors should be such fools as to gamble with their precious lives and health."

Here, in a few words, is summed up the conscientious medical man's opinion of his unworthy imitator. Not so long ago it was the practise of medical associations ruthlessly to expose the faker but so loud did he yell when the lash of scientific knowledge cut into his absurd theories that there were immediately drawn to his side numbers of sympathizers who imputed selfish motives to the medical profession. It was ever thus. The scroundrel who yells at his punishment, no matter what his crime, always gets a certain amount of misplaced symapthy.

But the Ontario judgment is a sad blow to the quack. It sounds very much like his doom in that province and if it has the effect of driving him elsewhere to "practice" other provinces may follow the lead of Ontario and strip him of his deceptive title. For the sake of humanity the sooner they do so the better.

From "Tranquillian," Canada, May, 1927.

NEW AMERICAN MEDICAL DIRECTORY

For more than twenty years the American Medical Association has been publishing a directory of the medical profession. Ten editions have appeared, the last one (1927) being just off the press.

The first edition (1906) contained 128,171 names of physicians in the United States, its dependencies and Canada. The new Tenth Edition includes 164,002 names. There is an increase of 2,644 over the previous edition. If the directory were merely a list of names and addresses of physicians it would have great significance. That information is valuable, but of far greater value is the fact that the directory gives proof of the right of each physician listed to practice medicine—namely, time and place of graduation and year of license. In addition, society membership, specialty and office hours are included. Capital letters indicate those who are members of their county medical society, and a special symbol follows the names of those who are Fellows of the American Medical Association.

The information concerning hospitals and sanitariums of the United States is another valuable and extensive feature. Descriptive data appears following the names of 7,816 hospitals and sanitariums such as type of patients handled, capacity, and name of superintendent or director.

The list of physicians in each state is preceded by a digest of the laws governing medical practice in that state; members of licensing board; state board of health; names of city, county and district health officers; officers of constituent state associations and component county and district medical societies. The book, in short, is one vast source of reliable data concerning the personnel of the medical profession and the institutions and activities closely related to it. It contains 2,575 pages and is sold for $15.00. Published by the American Medical Association, 535 North Dearborn Street, Chicago.

THE PRESIDENT'S PAGE

Arthur W. Rogers

LEST WE FORGET

WITH the A. M. A. endorsing and developing the problem of periodic examinations of apparently healthy individuals, when every state medical society is devising ways and means of getting this matter before the laity and to increase the interest of the medical profession, when many large corporations are examining their employees annually and insurance companies are offering this privilege gratuitously to their policy holders, when one commercial organization states it has in a few years examined over 400,000 applicants, and finally, when the public is practically demanding this service, it behooves the members of our state society to fall into line and familiarize themselves with the facts, possibilities and methods of this procedure. The State Medical Society of Wisconsin has ever stood for progressiveness and the best things in medicine; and we feel certain it will rise to the occasion of this, the greatest means of preventing sickness and prolonging life which has appeared in our generation.

We believe that many members of our profession lack interest in this matter because they have not given the subject proper study. There is not a weak link in the chain of reasons advanced for this procedure; therefore, we must get behind the movement and keep it going. It will take time to develop it to its best functioning.

One thing is certain—unless we medical men do this work, and it is our work and ours alone, someone else will; and then we shall have missed a glorious opportunity for ourselves and mankind.

AN OPPORTUNITY

EACH member was advised last month of a new means of informing his patients on the subject of Periodic Health Examinations. The State Society has secured permission of the State Board of Health to reprint in quantity the official leaflet on this subject.

The leaflet presents a splendid opportunity to the membership. Through its distribution to your friends and mine, thousands of our citizens will be advised in a direct and personal manner of the service available to them through the physician of their choice.

Two means of distributing this leaflet are authorized by the Council. The costs involved are indeed small; the results to be attained are indeed great. Every member should avail himself of this opportunity.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

Officers, 1927

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TERM EXPIRES 1929
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TERM EXPIRES 1929
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LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES

County	President	Secretary
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Barron-Polk-Washburn-Sawyer-Burnett	H. M. Coleman, Barron	D. L. Dawson, Rice Lake.
Brown-Kewaunee	E. S. Schmidt, Green Bay	M. H. Fuller, Green Bay.
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Clark	F. D. Jackey, Thorp	F. P. Neis, Thorp.
Columbia	A. F. Schmeling, Columbus	H. E. Gillette, Pardeeville.
Crawford	J. J. Kane, Prairie du Chien	C. A. Armstrong, Prairie du Chien.
Dane	W. D. Stovall, Madison	Hans H. Reese, Madison.
Dodge	L. M. Bachhuber, Mayville	A. A. Hoyer, Beaver Dam.
Door	John Hirschboeck, Forestville	T. C. Proctor, Sturgeon Bay.
Douglas	P. G. McGill, Superior	J. W. McGill, Superior.
Eau Claire and Associated Counties	G. W. Beebe, Eau Claire	H. M. Stang, Eau Claire
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Grant	E. C. Howell, Fennimore	M. B. Glasier, Bloomington.
Green	J. L. Fleck, Brodhead	J. F. Mauermann, Monroe.
Green Lake-Waushara-Adams	Orvil O'Neal, Ripon	H. A. Schulz, Fremont.
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Jefferson	W. C. Becker, Watertown	A. C. Nickels, Watertown.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	C. G. Richards, Kenosha	H. A. Binnie, Kenosha.
La Crosse	E. A. Smedal, La Crosse	N. P. Anderson, La Crosse.
Lafayette	W. W. Peck, Darlington	S. A. J. Ennis, Shullsburg.
Langlade	M. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	E. K. Morris, Merrill	W. H. Bayer, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	M. P. Andrews, Manitowoc.
Marathon	W. E. Zilisch, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	M. D. Bird, Marinette.
Milwaukee	C. H. Stoddard, Milwaukee	E. L. Tharinger, Milwaukee.
Monroe	H. B. Johnson, Tomah	H. H. Williams, Sparta.
Oconto	C. W. Stoelting, Oconto	C. J. Ouelette, Oconto.
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Pierce-St. Croix	Rolla Cairns, River Falls	J. W. Prentice, Deer Park.
Portage	G. H. Lawrence, Stevens Point	F. R. Krembs, Stevens Point.
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Shawano	R. C. Cantwell, Shawano	C. E. Stubenvoll, Shawano.
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Waukesha	C. C. Edmondson, Waukesha	J. F. Wilkinson, Oconomowoc.
Waupaca	T. E. Loope, Iola	A. M. Christofferson, Waupaca.
Winnebago	S. D. Greenwood, Neenah	R. H. Bitter, Oshkosh.
Wood	J. C. Hayward, Marshfield	V. A. Mason, Marshfield.

SOCIETY PROCEEDINGS

BARRON-POLK-WASHBURN-SAWYER-BURNETT

The June meeting of the Barron-Polk-Washburn-Sawyer-Burnett County Medical Society was held at the Land o' Lakes Hotel, Rice Lake, on the 7th of the month at 1:30 in the afternoon. The following program was given: Case Report, by Dr. E. J. Knapp, Rice Lake; Résumé of three cases, viz: "Pernicious Anæmia, Lymphatic Luekemia and Gas Bacillis" by Dr. H. M. Coleman, Barron; "The Effect of High Blood Pressure and Arteriosclerosis on the Nervous System," by Dr. W. H. Hengstler, St. Paul, Minn.; "Fractures of the Lower Radius," by Dr. L. E. Daugherty of St. Paul, Minn.

Following the scientific program, dinner was served in the private dining room of the new hotel, where a suitable dinner program was enjoyed. *D. L. D.*

CHIPPEWA

The Chippewa County Medical Society held its monthly meeting at the Northern Wisconsin Colony and Training School, State Home Park, on June 13th. The society was the guest of Dr. A. L. Beier, who had several interesting cases to demonstrate. Dinner was served at 6:30 p. m., during which the Colony orchestra played. Following the dinner two interesting papers were presented: "Several Problems in Pathology and Their Medico-Legal Aspect," by Dr. Edward L. Miloslavich, professor of pathology, Marquette University School of Medicine; "Clinical Relationship of the Nervous System to the Skull and Spinal Column," by Dr. Eben J. Carey, acting dean, Marquette School of Medicine, and director, Marquette University Dispensary.

The following members attended the meeting: Drs. Touranyeau, Kelly, Casey, Kershbaumer and Beier from the State Home; Drs. Blosmo and Butler, Menomonie; Dr. Amundson, Mondovi; Drs. Midelfart, Stang, Haig, Flynn, Maloney, Stollen and Nels Werner, Eau Claire; Drs. Harrington, Miloslavich and Carey, Milwaukee; Dr. Cooper, Colfax; Dr. Fortner, Bloomer; Drs. Schwartz, McHugh, McRae, Williams, Hatleberg, Somers and Henske, Chippewa Falls. *W. C. H.*

DANE

The annual field day and picnic of the Dane County Medical Society was held Wednesday, June 22nd. The physicians and their families met on the grounds of the State Hospital at Mendota at 4 o'clock in the afternoon. Baseball games, sports, and other activities, plus the picnic supper, comprised the informal program. *W. J. B.*

KENOSHA

Dr. Charles Parker, head of the orthopedic division of Rush Medical College, Chicago, and Dr. L. D. Smith, orthopedic surgeon at the Medical School of Marquette University, Milwaukee, spoke before the Kenosha County Medical Society on June 17th. Their presentations were in the nature of a report on their observations at a public clinic held that day in the Kenosha Court House building. During the morning Dr. Parker conducted the examinations and diagnoses. He was joined in the afternoon by Dr. L. D. Smith. Both physicians examined scores of children, looking over each disability, prescribing in cases what treatment could be taken in the home, and wherever necessary, prescribed operations that would restore many useless and handicapped limbs to their full use.

The clinic was held under the auspices of the Kenosha County Medical Society, the Wisconsin Association for the Disabled, the Kenosha County Survey Committee, and other persons interested in helping those children in the city and county where it was found that this aid and advice was most necessary. *H. A. B.*

LA CROSSE

The La Crosse County Medical Society has had three meetings during the last two months. The first one was held April 27th at the Pioneer Hall at 6:30 p. m. The regular order of business was dispensed with and a banquet was enjoyed. Dr. Evans of the Ætna Insurance Company spoke on "Compensation Insurance," and Dr. Victor Jacobson, a visiting pathologist, on "Modern Laboratory Facilities and Their Relation to the Hospital."

The second meeting was held on May 25th at the Oak Forest Sanatorium. A splendid dinner was served by the hospital staff. The society unanimously went on record instructing the delegate Dr. W. E. Bannen, to vote for the following amendment at the state meeting at Eau Claire: "Councilors shall be elected by their respective councilor district societies at sessions held prior to the annual meeting of their society; or, in default thereof, by the House of Delegates." Dr. Carl P. Ruffenthal, West Salem, was elected a member of the society after his application had been approved by the censors.

A special meeting of the society was held on May 31st, when it was decided to entertain the Seventh District Society in August. The May bulletin sent out from the state headquarters was discussed. The society went on record endorsing the reappointment of Dr. Flynn. A motion was made and unanimously carried, instructing the secretary to write all county society secretaries, requesting them to send in resolutions to Governor Zimmerman urging the reappointment of the present secretary of the State Board of Medical Examiners, Dr. Robert E. Flynn; also that a committee of the La Crosse County Medical Society be appointed to interview Governor Zimmerman regarding this reappointment. *N. P. A.*

MARATHON

A clinic on Gastrointestinal Disorders and Infant Feeding was conducted at St. Mary's Hospital, Wausau, on May 26th, by Dr. R. C. Blankinship and Dr. J. E. Gonce, Madison, under the auspices of the Marathon County Medical Society. Following the clinic, Dr. Blankinship addressed the members on "Diagnosis in Gastrointestinal Disorders" and Dr. Gonce presented a paper on "Infant Feeding". *V. E. E.*

MARINETTE-FLORENCE

The members of the Marinette-Florence County Medical Society met on June 23rd at their regular monthly dinner-meeting at Marinette. Dr. W. H. Alexander, chief

surgeon of the Ford Motor Company, of Iron Mountain, Mich., addressed the physicians on "Fractures". Dr. A. T. Nadeau, Marinette, presented an interesting paper on "Club Feet". *M. D. B.*

MILWAUKEE

The members of the Milwaukee County Medical Society were invited by the Milwaukee Academy of Medicine to hear Dr. R. W. Scott of Cleveland, Ohio, on June 14th at the Medical Arts Building. He spoke on "Cardiovascular Disease as Seen in a Series of Six Hundred Autopsied Cases". *E. L. T.*

OUTAGAMIE

"Coronary Diseases of the Heart" was the subject discussed by Dr. Arthur R. Elliott, Chicago, at a meeting of the Outagamie County Medical Society on May 26th at Hotel Conway, Appleton. Dr. Elliott is chief of the medical staff at St. Luke's Hospital, Chicago, and is professor of internal medicine at the University of Illinois Medical School. Fifty-five physicians from Appleton, Oshkosh, Neenah, Menasha and Green Bay were present. *C. D. N.*

PIERCE-ST. CROIX

At a meeting of the Pierce-St. Croix County Medical Society held at the Hudson Sanatorium on May 25th, Dr. Archie H. Beard, associate professor of medicine, University of Minnesota, and Dr. W. S. Middleton, of the medical staff of the Wisconsin General Hospital, University of Wisconsin, presented interesting scientific papers. A business meeting followed, at which Dr. C. F. King, Hudson, and Dr. E. L. Boothby, Hammond, were elected honorary members of the society in appreciation of their many years of service in the medical profession and to the people of their respective communities.

The next meeting of the society will be held at Prescott, where the members will be guests of Drs. Jones and Dill.

The following members were at the Hudson meeting: Drs. H. E. Perrin, Star Prairie; E. B. Bradford and L. E. Newton, Hudson; Bartholomew Kunny, Baldwin; J. W. Prentice, Deer Park; O. Hoyt Epley and Joshua H. Armstrong, New Richmond; G. M. Dill and L. E. Jones, Prescott; Rolla Cairns and A. E. Gendron, River Falls; Wm. A. Lumley and Geo. C. Munger, Ellsworth; E. G. Nylander and N. V. Sandin, Maiden Rock; Oscar B. Anderson, Plum City, and A. E. McMahon, Glenwood City. *J. W. P.*

RACINE

The annual picnic of the Racine County Medical Society was held on Wednesday afternoon, June 22nd, at Hotel Antlers, Brown's Lake, Racine County. Dinner was served at six. *S. J.*

ROCK

The Rock County Medical Society held its regular monthly meeting at the Janesville Y. M. C. A. Tuesday evening, May 31st. Following the dinner, Dr. Mark T. Goldstine, professor of gynecology, Chicago, addressed the society on "Abnormalities of Endocrine Function with Special Reference to the Ovary". Dr. Edward Miloslavich, professor of pathology, Marquette University Medical School, Milwaukee, spoke on "The Importance of Post Mortem Examinations to the General Practitioner". The meeting was well attended and interesting discussion followed the presentation of the papers. *H. E. K.*

WALWORTH

The members of the Walworth County Medical Society, accompanied by their wives, met at Lake Lawn Hotel, Delavan, June 24th. Following their banquet, they were entertained by a very excellent and detailed discourse on the symptoms and treatment of the more common skin diseases as seen by the general practitioner. Dr. R. L. McIntosh, of the Madison General Hospital, who delivered the talk on skin diseases, was greatly appreciated. The next meeting of the society is to be held in Whitewater, in August. *T. P. K.*

MILWAUKEE ACADEMY

On the evening of June 14th Dr. R. W. Scott, associate professor of medicine, Western Reserve University, Cleveland, Ohio, spoke before the Milwaukee Academy of Medicine. His subject was "Cardiovascular Disease as Seen in a Series of Six Hundred Autopsied Cases".

Gifts of periodicals have been received from Drs. Gray and Taylor, Dr. L. Boorse and Dr. Henes for the Academy Library. Dr. Elmergreen and the State Medical Society have also made gifts of books and medical journals. *D. E. W. W.*

MILWAUKEE PEDIATRIC

The Milwaukee Pediatric Society held a meeting at the Milwaukee Children's Hospital on June 8th. Dr. George F. Dick of Chicago read a paper on "Scarlet Fever" and Dr. Karl E. Kassowitz, Milwaukee, presented a report on "The Bactericidal Effect of Quartz Light."

SOCIETY OF OPHTHALMOLOGY

Medical men from various parts of the state and Chicago and Minneapolis gathered in Marshfield during the last of May for a meeting of the Central Wisconsin Society of Ophthalmology and Oto-Laryngology, which was held at St. Joseph's Hospital and in the auditorium of the nurses' home.

Among the speakers having part in the program were: Drs. Thomas L. Tolan, Milwaukee; W. F. Monerieff, Chicago; F. S. Cook, Joseph C. Baird, Arthur Margot and John B. Ziegler, Eau Claire; Dr. McCormich, Marshfield; Dr. Nelson M. Black, Milwaukee, and Dr. Fred J. Pratt, Minneapolis.

NEWS ITEMS AND PERSONALS

Dr. Otto H. Foerster, Milwaukee, was elected president of the American Dermatological Association at its annual meeting in Baltimore the last of May.

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The staff of the medical school of the University of Wisconsin was supplemented by the appointment, at the May meeting of the University Regents, of experts in radiology and physiological chemistry.

Dr. E. A. Pohle, now associate professor of roent-

genology at the University of Michigan, was appointed professor of radiology and Dr. Edgar J. Witzemann, now a biochemist at the Mayo Clinic, Rochester, Minn., was appointed assistant professor of physiological chemistry.

Dr. Pohle's appointment was made effective July 1, 1927, but he was granted leave of absence without pay until July 1, 1928. He will develop the therapeutic work with radium and x-ray in the radiological section of the Service Memorial Institute, the building for which is now being erected at the University.

Dr. Pohle is a German by birth and early education. He did graduate work in the laboratory of Dessau, one of the leading German radiologists. From 1921 to 1923, he had charge of the roentgenological laboratory at the Mount Sinai hospital in Cleveland, O. Since 1923 he has been in charge of therapeutic work in radiology at the University of Michigan.

Dr. Witzemann, who joins the staff for 1927-28, was trained at James Millikin University and Ohio State University, receiving the Ph. D. degree from the latter school in 1912. From 1912 to 1925 he was chemist in the laboratory for clinical research of the Otto S. A. Sprague Memorial Institute, Chicago, and since 1925 has been first assistant in the section of biochemistry of the Mayo Clinic.

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Dr. William Snow Miller has recently returned from the meeting of the National Tuberculosis Association, which was held in Indianapolis. Dr. Miller gave two addresses before the association and exhibited a series of models and photographs connected with the study of tuberculosis, which he has been carrying on for the past four years under a special grant from the association.

In recognition of his work he was made an honorary member of the association. His investigations will be continued.

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Dr. J. Newton Sisk of the Jackson Clinic, Madison, gave an interesting talk on the "Uses of the X-Ray" before the Rotarians of Stoughton. He illustrated his talk with lantern slides showing x-ray pictures.

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Dr. George W. McCarthy, Kenosha, recently returned from a tour of the Mediterranean countries, including Egypt and the Holy Lands. He returned by way of Central Europe and while abroad spent several weeks of study in the clinics of Vienna.

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The members of the Milwaukee Pediatric Society were addressed recently by Dr. George F. Dick, Chicago, who discovered the causes of scarlet fever. The lecture was held at the Milwaukee Children's Hospital and was well attended.

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Headed by Dr. William S. Middleton, Wisconsin General Hospital, Madison graduates of the University of Pennsylvania's School of Medicine are taking an active part in a nation-wide effort to raise $3,050,000 for further development of the University's units for medical education and service.

Dr. Middleton, a graduate of the School of Medicine in the class of 1911, is one of nearly 100 group chairmen leading alumni in various cities in their effort to raise funds for the university's medical development.

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Dr. A. E. Meinert, who for nearly a year has been associated with Dr. H. A. Jegi, Galesville, left on June 10th for Winona, Minnesota. He is now established with the Winona Clinic.

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Dr. V. S. Falk, Stoughton, has been appointed as acting city health officer during the absence of Dr. A. L. Olson, who is on a three months' sojourn in Europe.

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Dr. W. A. Henke, chief of staff of the Grandview Hospital, La Crosse, was elected president of the Wisconsin Hospital Association at its annual meeting held in Milwaukee on May 23rd and 24th.

Other officers are: First vice president, Miss Grace T. Crafts, Madison; second vice president, Miss Levina S. Dietrichson, Plymouth; secretary and treasurer H. K. Thurston, Madison. Four persons were named to the State Board of Health, one of whom will be selected later to be a member of the State Board of Nurses' Education. Those chosen to this board are: Charles F. Karrow, Milwaukee; C. J. Wollan, La Crosse; H. K. Thurston, Madison, and Dr. R. C. Buerki, Madison.

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"It is up to every good citizen to help prevent communicable disease," said Dr. M. R. French, of the Milwaukee Health Department, at a recent meeting of the Professional Men's Club at the Yacht Club. "It is the duty of the parent, the teacher, the neighbor, or anyone who suspects another of having or carrying disease, to report it to the health department."

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Dr. H. C. Werner was elected president of the Fond du Lac Community Chest at a meeting of the board of directors on Wednesday, June 8th, at the Association of Commerce rooms. Dr. Werner will succeed S. D. Wyatt, who was unable to continue in that capacity.

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Dr. R. P. Potter, one of the Marshfield Clinic staff of physicians, submitted to an operation at St. Joseph's Hospital recently for the removal of gallstones. His condition was very favorable at last reports.

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A program of unusual interest and benefit was arranged for county health officials who gathered at the annual spring meeting of the County-Wide Health Committee. The meeting was held on June 10th at the Chamber of Commerce rooms, Oshkosh.

Dr. V. A. Gudex, the newly appointed district deputy health officer for that district, was one of the main speakers at the meeting. He discussed "Rules Governing the Control of Contagious Diseases and Their Prevention". Dr. E. J. Campbell, Oshkosh health commissioner, spoke on "The Relation of City Health to that of the County". The concluding speaker was Dr. I. D. Wiltrout, of Chippewa Falls, whose subject was "Mental Health of Children". The election of officers and a short business meeting concluded the session.

Dr. Wm. J. Murphy, who for the past few months has been practicing at Bear Creek, has become associated with Dr. A. I. Haugen, Stanley, in the practice of medicine and surgery. Dr. Murphy is a graduate of the University of Wisconsin and of Northwestern University Medical School.

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At the June meeting of the St. Mary's Hospital staff, Madison, Dr. C. K. Schubert was elected to staff membership. Dr. Schubert is associated with Dr. C. G. Dwight at the Dwight and Schubert Clinic, which specializes in eye, ear, nose and throat work.

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Dr. Byron Nixon, of the Kenosha Clinic, sailed the last of May for Cherbourge, France, preparatory to doing post-graduate work in the clinics of Berne, Vienna, Munich and London.

Dr. Nixon's itinerary necessitates his absence from Kenosha for an indefinite period.

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Dr. Charles T. Granger, head of the Granger Clinic and Hospital of Rochester, Minn., visited Beloit some time ago to study the situation with a view of moving his clinic of fifteen physicians and surgeons from Rochester to Beloit.

Dr. Granger was particularly interested in the plans for the new municipal hospital. He is also interested in the establishing of a nurses' training school in connection with the institution. The Granger Clinic has been in Rochester for thirty-six years.

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Dr. G. Windesheim, public health director of Kenosha, was the principal speaker before the Kenosha Kiwanis Club at a weekly luncheon during May at the Elks' Club.

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Newly elected officers of the Madison General Hospital staff were announced recently by J. O. Wallestad, auditor of the hospital. Dr. W. T. Lindsay was named head of the staff. Other officers are: Dr. C. A. Harper, vice president; Dr. L. V. Littig, secretary, and Dr. H. M. Kay, treasurer.

The executive committee is composed of Drs. R. T. Cooksey, W. T. Lindsay, H. P. Greeley, C. G. Dwight and H. M. Kay.

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Physicians of Green Bay and De Pere have expressed themselves as being heartily in favor of the present site at Hickory Grove for the new tuberculosis sanatorium. Numerous organizations, too, have expressed themselves as favoring the site on Fox River.

A comprehensive survey of sentiment has been secured by means of personal interviews and circulation of a resolution favoring the present site. Those who endorse the present site include: Drs. T. J. Oliver, city health commissioner, Green Bay; I. E. Levitas, H. P. Rhode, E. G. Nadeau, E. S. Schmidt, A. V. Mattern, F. L. Crikelair, C. J. Chloupek, Ralph Carter, A. J. McCarey, J. P. Lenfestey, G. F. Goggins, J. J. Bellin, R. M. Burdon and W. W. Kelly.

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The two sturdy legs upon which modern surgery stands are anesthesia and antisepsis, discoveries of major importance to that profession, according to Dr. Erwin R. Schmidt, chief surgeon at the Wisconsin General Hospital, who addressed members of the American Business Club at the Loraine Hotel, Madison.

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Dr. G. A. Ribenack, practicing physician at Bloomer during the past eight years, has moved to the village of Haugen, where he has opened an office.

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Dr. H. A. Robinson, of Kenosha, was the chief speaker at the annual convention of the Illinois Chiropodists Society, held at the Morrison Hotel in Chicago.

"Don't blame the shoes for bunions," said Dr. Robinson "but blame our ancestors. We inherited weak sesamoids; hence we have dislocated toe joints, causing bunions."

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Before an audience of more than 450 persons, composed of members of the faculty and medical students at the University of Wisconsin, Dr. Morris H. Fishbein, Chicago, editor of the J. A. M. A., recently ridiculed fads and quackery.

Dr. Fishbein was introduced by President Glenn Frank of the University. In introduction, President Frank said, "Dr. Fishbein belongs to the rare and almost extinct specie of 'gad-fly'. Science, as well as religion and politics, need its 'gad-flies'. Dr. Fishbein is to medicine what Dineen is to democracy."

—△—

"The day is coming soon when no dentist or physician will dare to practice alone. We will all practice in groups. I don't see how a medical man dares to practice alone, relying solely on his own judgment," said Dr. Joseph Colt Bloodgood, cancer authority and surgeon at Johns Hopkins University, Baltimore. He spoke to the Dental Forum, a private dental club which had as guests the county medical and dental societies and other medical and dental men from southern Wisconsin. The meeting was attended by 150 at the Milwaukee Athletic Club.

Dr. Bloodgood devoted most of his talk to cancer. "There are just two cures," he said, "surgery and radiation. Both of these seem to have been developed to their limit. Where surgery cannot be done and where radiation has failed, it is justifiable to try injection of a lead solution into the veins. Unless we discover something new, the only way to cut down cancer deaths is to teach the public to have lumps, lesions and possible cancers examined immediately."

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Dr. Monrad-Krohn, professor of neurology at Oslo University, Norway, and Dr. Peter Bassoe, of Chicago, were entertained in Madison over a week-end last month by Dr. W. F. Lorenz and Dr. J. H. Lee. The physicians were entertained at dinner by Dr. Lee at his home and Dr. Lorenz gave a luncheon at the University Club for them, at which the guests were Drs. J. S. Evans, E. R. Schmidt, W. J. Bleckwenn, Mabel Masten, A. S. Loevenhart, J. H. Lee and C. R. Bardeen.

Dr. Monrad-Krohn was in this country to attend the A. M. A. convention and to visit medical centers.

Dr. Edward L. Miloslavich, director of the department of pathology and bacteriology, Marquette University Medical School, Milwaukee, was invited to address the District Attorneys' Convention at Green Bay, May 12th, on the subject of "Medical Testimony". On May 14th, Dr. Miloslavich delivered a paper on "Occurrence of Lipoids in Urine and Their Diagnositic Importance" before the Sixth Annual Meeting of the American Society of Clinical Pathologists at Washington, D. C.

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Drs. O. H. and H. R. Foerster, Milwaukee, announce the association with them of Dr. Lester M. Wieder, who has been instructor in dermatology for the past five years in the Medical Department of the University of Michigan, Ann Arbor, Michigan.

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Dr. W. G. Sexton, of Marshfield, spoke before the staff of the University Hospital, Madison, during June. His subject was "The Clinical Significance of Anomalies of the Genito-Urinary Tract."

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"Ninety-eight per cent of the people today have mouth infections and too little attention has been given to the diseases of the mouth and the prevention of them," Dr. M. N. Federspiel, of Milwaukee, head of the Oral Surgery Department of Marquette University, told seventy-five members of the Central Wisconsin Dental Society at its annual meeting held in Wausau during June.

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Sanitation and food are two of the most important things which go to make up camp life, and both must be carefully looked after, according to Dr. Walter G. Darling, Milwaukee, chairman of the sanitation and diet committee of the Indian Mound Camp Committee. Working with Dr. Darling is Dr. J. Gurney Taylor. The committee outlines the diet for the campers, making up the menus for the entire summer so that the scouts attending camp have a balanced ration.

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Dr. Philip Corr, Juneau, will be associated with Dr. C. H. Bunting, of the University of Wisconsin Medical School, after August 1st.

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Dr. Walter A. Brussock of Milwaukee, and more recently of Oshkosh, has recently been granted the degree of Master of Medical Science for graduate work in internal medicine at the 187th commencement of the University of Pennsylvania in Philadelphia. Dr. Brussock is assistant chief resident physician at the Philadelphia General Hospital, being in charge of the medical departments.

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Among recent additions to the medical fraternity of Madison is Dr. Albert W. Bryan, who comes to join the staff of the Jackson Clinic, where he will be associated with Dr. H. E. Marsh in the department of general diagnosis, internal medicine and diseases of the nervous system.

Dr. Bryan was with the Mayo Foundation for three years. He comes to Madison from Lincoln, Neb., where he has been with the Lincoln Sanitarium the past years.

Dr. C. Kenneth Cook has recently returned from the Illinois Steel Company Hospital at Gary, Ind., and several Pittsburgh hospitals, where he took courses in bone fracture and industrial accident surgery in preparation for his service at the Jackson Clinic as assistant to Dr. James A. Jackson in the care of emergency accident and orthopedic surgery.

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Believed to have been a victim of selenium poisoning, Dr. Victor Lenher, 54, nationally recognized as one of the foremost inorganic chemists of this country, died at a Madison hospital on June 12th, after an illness of six months.

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The Racine County Medical Society petitioned the city council to make every inducement to retain Dr. W. W. Bauer as local health commissioner. Dr. Bauer recently tendered his resignation to accept an offer from the Wisconsin Anti-Tuberculosis Association.

The medical society pointed out in its petition, which was read at a recent council meeting, that Dr. Bauer has placed the local health work on a high plane, and recommended that every inducement be offered to retain his services.

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Dr. A. M. Carr, city health officer of Madison, was appointed a member of the State Board of Control to succeed Mr. Grant C. Haase, by Gov. Fred R. Zimmerman, during the third week in June. Dr. Carr came to Madison from Trenton, N. J., on September 1st, 1925, to accept the city health officership.

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Dr. Lloyd O. Helmes has recently become affiliated with The Schiek Clinic, Rhinelander, where he has charge of pediatrics. Dr. Helmes has been chief resident physician at the Milwaukee Children's Hospital for the past year.

Prior to his service at the Milwaukee Children's Hospital, Dr. Helmes had a post-graduate course in pediatrics under Dr. Marriott at St. Louis Children's Hospital and served under him for over a year in that institution.

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A shortening of the time physicians must spend as students was advocated by Dr. Dean Lewis, professor of surgery at the Johns Hopkins University, in an address before the first graduating class of the Medical School, University of Wisconsin, and three hundred doctors who had taken part of their work at the university, assembled for their reunion banquet at the Wisconsin General Hospital, June 20th. Dr. Lewis declared that physicians get much of their training after they leave school. However, he commended a school where practicing physicians might keep up with their studies.

"One ability the modern physician has lost that the older generation of doctors was expert in, is the ability to make terse, accurate, clinical observations," he said. He also expressed the need of some change being made in schools for the encouragement of the student who is an independent investigator.

Dr. Dean Lewis received the honorary degree of Doctor of Science during the recent commencement at the Medical School.

Dr. Rock Sleyster, trustee of the American Medical Association and treasurer of the State Society, has just returned following addresses before the Massachusetts and Maine State Medical Society meetings.

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Dr. Harold Heath, at present with the University of Wisconsin Student Clinic, will take over the practice of Dr. Philip Corr, Juneau, on August 1st.

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Dr. G. J. Warnshuis, formerly of the Burdick Corporation, Milton, has resumed private practice in Milwaukee. Dr. Warnshuis will give special attention to physical therapy.

DEATHS

Dr. George F. Kelly, Milwaukee, died Sunday night, May 29th, at Sacred Heart Sanitarium, which he entered just two weeks previous to his death. Dr. Kelly was born in the year 1881 and was graduated from the Chicago College of Medicine and Surgery in 1915. He was licensed to practice in the state of Wisconsin the same year.

Dr. Kelly was a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his wife.

Dr. Asa Norman Jones, Reedsburg, died Friday, May 13th, at the Reedsburg Hospital after a prolonged illness. Dr. Jones was born at Jonesville, Adams County, on August 11, 1864, and entered Rush Medical College, Chicago, in 1887, from which he graduated in the year 1890.

The deceased was a member of the Sauk County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. Dr. Jones managed the Reedsburg Hospital for nearly twenty years. He is survived by his wife, his aged father, and a son.

Dr. Joseph Schneider, Milwaukee, died at his home on Saturday, June 4th, following an illness of several weeks. Dr. Schneider was 82, having been born in Weigelsdorf, Silesia, December 10, 1845. He attended school at Breslau and the University of Wuerzburg and following his graduation practiced as a general physician until the outbreak of the Franco-Prussian war in 1870. After his discharge he again resumed his studies, giving special attention to otology and ophthalmology.

During the following ten years Dr. Schneider attended clinics in Vienna, Paris, London and Berlin and in 1881 came to America in charge of a patient, intending to attend clinics in this country and then return to Europe. After some months, he decided to remain and selected Milwaukee as his future home, opening offices at 473 East Water St., where he practiced until his death.

During the forty-five years Dr. Schneider practiced here it is said that more than 145,000 afflicted persons from all parts of the United States and other countries sought him in his simple offices. In 1925 Dr. Schneider returned to Europe for a visit and at that time he was made a senator of the University of Wuerzburg.

Dr. Schneider was a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin, the American Medical Association and numerous other medical societies both here and in Europe. He was for many years a director of St. Joseph's Hospital and it was in this institution that most of his operations were performed. Mrs. Schneider died but a few months ago. The deceased is survived by two daughters.

MARRIAGES

Dr. Robert B. Montgomery, La Valle, to Miss Harriet R. Pearson, also of La Valle.

CORRESPONDENCE

CONGRATULATES SOCIETY

COMMITTEE ON LYE LEGISLATION
American Medical Association
Section of Laryngology
128 South Tenth Street, Philadelphia

Mr. J. G. Crownhart, Secretary, June 20, 1927.
State Medical Society of Wisconsin,
153 E. Wells, Milwaukee, Wis.

My dear Mr. Crownhart:

Hearty congratulations on your good work and many thanks for your kind letter reporting the passage of lye legislation in Wisconsin. It is especially gratifying to know that the model lye bill has been followed.

I cannot tell you how much personal happiness comes my way as a result of your good work in Wisconsin. It certainly will be the means of saving the lives of many children in your state in future years,

With kind regards, Very truly yours,
CJ/A CHEVALIER JACKSON.

INTER-STATE MEETING

Milwaukee, Wisconsin,
June 2nd, 1927.

Mr. J. G. Crownhart, Secretary-Managing Editor,
The Wisconsin Medical Journal,
153 E. Wells Street,
Milwaukee, Wisconsin.

Dear Mr. Crownhart:

For any use to which you may put the following information in the columns of the Wisconsin Medical Journal, please be advised as follows:

The Annual Assembly of the Inter-State Post Graduate Medical Association of North America, will be held at Kansas City, Missouri, October 14th to the 21st inclusive, 1927. The Annual Clinic week of the Kansas City Southwest Clinical Society, will be merged into our Assembly program and will constitute the pre-assembly clinic features of our program. On the 14th and 15th of October, there will be held in the hospitals of Greater Kansas City, operative and diagnostic clinics by men of the outstanding clinical programs in the southwest.
unusually well conducted and have constituted one of the outstanding clinical programs in the southwest.

The program of the Inter-State will begin at the usual early hour of seven o'clock, Monday morning, October 17th, and consisting of diagnostic clinics and didactic presentations by the most renowned clinicians and teachers of America and Europe, will continue until late Friday afternoon, October 21st. Dr. George W. Crile,

as chairman of the program committee, has prepared an unusually attractive and helpful program.

All sessions of the Assembly will be held in the magnificent new Ararat Shrine Temple Building. The largest scientific and technical exhibit in the history of our Association will form an important feature of the Assembly, and at this date almost one hundred individual firms will be represented in the exhibit halls; the entire exhibit will be housed in the Ararat Shrine Temple Building.

A detailed program with full information covering the Assembly, will be prepared and mailed to all medical men in good standing throughout the United States and Canada. This program will be mailed sufficiently early to enable all to make reservations at Kansas City.

All first class hotels at Kansas City will cooperate and will provide ample accommodations for medical men of the country. The Hotel Muehlebach has been designated the Headquarters Hotel, and all reservations for accommodations at the Headquarters Hotel, or any other hotel, are to be made through the manager of the Convention Bureau of the Chamber of Commerce of Kansas City, Missouri.

Reduced railroad rates on the certificate plan have been granted by all railroads in the United States and Canada. All local medical organizations, including the Jackson County Medical Society (Missouri), the Wyandotte County Medical Society (Kansas), the Kansas City Academy of Medicine, the Kansas City Clinical Society and the Kansas City Southwest Clinical Society, will act as hosts to our Association. Dr. E. H. Skinner of Kansas City is the general chairman for local committees, and he has gathered about him an exceedingly active and progressive group of medical men to assist in the conduct of what should prove to be one of the greatest medical assemblies ever held.

With very comfortable railroad service from Wisconsin to Kansas City, and especially from Milwaukee direct to Kansas City, it is hoped that the profession of Wisconsin will avail themselves of what the Inter-State Assembly has to offer them.

With kind personal regards, I am,

Yours very sincerely,

EDWIN HENES, JR., M. D.,
Executive Secretary.

INTERNESHIP TEDIOUS

Hospital for the Insane,
Mendota, Wisconsin.

Mr. J. G. Crownhart, Managing Editor,
153 E. Wells Street,
Milwaukee, Wisconsin.

Dear Sir:

Recently in the legislature was passed a law which required a year's interneship before allowing a medical student to take his state board examinations to practice. It seems to us that the whole purpose of an interneship is thereby cast aside due to the fact that that law will automatically forbid an interne to prescribe any drugs or to treat a patient in any way. If it is necessary that there be such a law, it seems to me that it would be much more advisable to withhold the doctor's degree from the university than to prevent an individual from taking his state board examinations.

Perhaps when some of the doctors realize that being gotten up in the middle of the night to give an order for morphine which his interne was formerly allowed to do, they will reconsider the advisability of such a law.

The basic science law was to prevent quacks from practicing medicine. I think its purpose was very commendable. But why must there be a law which will automatically make an interneship a rather tedious affair in which the interne is just part of a machine and give him no responsibility whatever?

We would like to have your opinion on this matter. We are senior students at the University of Wisconsin. If we are misinformed as to the content of this bill, please correct.

Yours very truly,

FRANK N. MASON,
H. VANDER KAMP.

SNOWMOBILE DEPRECIATION ALLOWED

Hon. A. J. Myrland, May 20, 1927.
Secretary, Wisconsin Tax Commission,
Madison, Wisconsin.

Dear Mr. Myrland:

Sometime ago I presented to you and Judge Conway the following facts for consideration by the commission as a whole:

It has come to my attention that in some portions of northern Wisconsin income tax assessors are refusing to allow depreciation to physicians on more than one automobile, and that this prevents such physicians from securing depreciation on a snowmobile, which many of them must necessarily use to make calls possible in the winter.

I stated that under our interpretation of the law, the physician is entitled to depreciation on as many automobiles or other vehicles as he actually uses in his business, just as he is entitled to depreciation on all other equipment which he actually uses in his business.

Will you advise me at your convenience whether the commission sustains this opinion?

With kind personal regards, I am,

Sincerely yours,

J. G. Crownhart,
Secretary.

WISCONSIN TAX COMMISSION.

Mr. George Crownhart, Madison, Wis.
Secretary, May 24, 1927.
State Medical Society of Wisconsin,
153 E. Wells Street,
Milwaukee, Wisconsin.

Dear Sir:

We have yours of May 20th stating that in some portions of northern Wisconsin physicians are compelled to use what is known as a snowmobile in order to make their calls possible in the winter time, and you inquire whether such physicians are entitled to a depreciation on such machine besides the automobile which they use in summer.

In reply you are advised that it would appear to us such a vehicle, if it is necessary for the use of the physician in making his calls and earning his income, should be allowed a proper depreciation.

Very truly yours,

WISCONSIN TAX COMMISSION,
By A. J. Myrland,
Secretary.

Dr. Frank N. Mason, June 6, 1927.
Dr. H. Vander Kamp,
Hospital for the Insane,
Mendota, Wis.
Gentlemen:

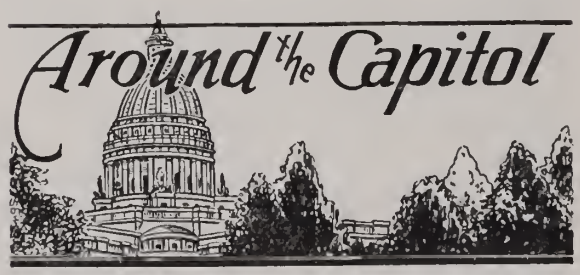
I am much interested in your letter protesting against the passage of a bill revising the medical practice act as it pertains to physicians, and particularly that section which makes an interneship a prerequisite to taking the medical board examination and licensure in Wisconsin.

This provision is now to be found in the laws of Alaska, Delaware, Illinois, Iowa, Michigan, New Jersey, North Dakota, Pennsylvania, Rhode Island, South Dakota, Utah and Washington. Its adoption in Wisconsin was proposed at the last meeting of our house of delegates without discussion or objection. It was the formal recommendation of the Board of Medical Examiners, accepted by our committee on public policy and contained in the revision bill, 168-S, now a law.

I hardly believe that the law will work the hardships you foresee. The proposal was contained in a booklet mailed by the Board of Medical Examiners to every physician in this state, and so far as I know, no objections were received. If, however, the law in effect works undue hardship and injustice, there is no question but what the Board of Medical Examiners will be the first to propose its change.

I appreciate your calling this to my attention that we may particularly watch this section as it is applied in practice.

Most sincerely yours,
J. G. CROWNHART,
Secretary.



That a grocer may sell medicated chewing gum is the opinion of the attorney general to the State Board of Pharmacy. It was stated in the request for an opinion that chewing gum contains laxatives.

"From your description of the preparation," declares the opinion of the attorney general, "I do not see how that can be done under the provisions of our statutes. You do not claim that it is a poison and it seems to be sufficiently labeled and described so that I do not think it would violate the provisions of our statutes to have it sold in the manner you have described.

"I suppose there are a great many things sold in grocery and confectionery stores that are a laxative to some at least, so I do not think that alone would require its sale to be confined to drug stores."

* * *

The State Board of Health in an opinion has advised officials that there is no law which relates to poison ivy under which it can be abated as a nuisance. Poison ivy is considered a noxious weed and should be destroyed as such and not under the nuisance statute.

* * *

In an opinion by the Department of Public Instruction it is held that school district meetings must be held on July 5, this year. The annual school district meeting, in order that the business transacted may be valid and binding upon the district, must be held this year on Tuesday, July 5, owing to the fact that the Fourth of July is a legal holiday. This command of the statute is imperative and the fact that it might be more convenient to hold the election some day prior to July 5 must not be entertained. The statute must be obeyed.

* * *

Members of a Madison family now occupy both the highest and lowest judicial positions in the state.

Justice E. Ray Stevens, formerly circuit judge, is now a member of the supreme court, Wisconsin's highest tribunal, while his son, Myron, who recently became an attorney, has been elected to the position of justice of the peace in the town of Madison.

* * *

Governor Fred R. Zimmerman has signed contracts for the construction of a new infirmary building at the Wales sanatorium for tuberculous patients, at a total cost of $176,343.50. Plans and specifications for the building were prepared by Arthur T. Peabody, state architect. The building will have a bed capacity to care for 80 patients and will be equipped with x-ray, heliotherapy facilities and other modern equipment to care for all types and stages of tuberculous cases.

M. M. Moen Company, Mason City, Iowa, won the general construction contract on the building; J. E. Robertson Company, Wauwatosa, the heating and plumbing contract, and Ray A. Phelps, Beloit, the electrical contract.

* * *

A speed limit of 40 miles per hour on highways outside of city limits is now effective. Gov. Fred R. Zimmerman has signed the Edwards bill, which provides that "in any case where such speed would be unsafe it shall not be lawful". This provision subjects the motorist to greater liability of being found guilty of reckless driving should an accident occur while a car is being operated within the legal speed limit or in excess of it.

Other limits specified are 20 miles per hour within cities, except in congested districts; 15 miles passing school buildings during sessions; 15 miles when approaching within 50 feet an intersection of highways where a driver's view is obstructed; 15 miles at curves or on a grade where driver's view is obstructed; 20 miles in business districts when traffic is controlled at intersections; and 20 miles in residential sections.

* * *

The campaign against industrial accidents in Wisconsin resulted in reducing their number during the first five months of this year, as compared with the first five months of last year, by 1,037, according to figures compiled by the state industrial commission.

R. G. Knutson, a member of the commission, announced that the commission had found that the average cost of an industrial accident was about $204. The direct finan-

cial saving as a result of anti-accident campaign, therefore, amounts to more than $200,000 during the first five months compared.

The first five months of 1926 recorded 10,898 industrial accidents. In the first five months of this year there were but 9,861. Close cooperation of Wisconsin industries with the industrial commission is credited by Commissioner Knutson.

* * *

Assemblyman Frank L. Prescott's bill relating to a closed season for hunting in Milwaukee County, if enacted into law, "will make it illegal to kill a rat, a mouse, a mole, a bat, a gopher or a woodchuck in Milwaukee," Governor Fred R. Zimmerman informed the assembly in returning the bill with his veto. The veto added, "It would likewise make it illegal for anyone to kill a hawk, a crow or a sparrow" in Milwaukee County.

* * *

An interim committee bill introduced by Senator Chase of Oconto, which proposes to repeal the state appropriation for county supervising teachers and placing paying and hiring of the teachers in the hands of county boards, was defeated, 18 to 14.

* * *

World War veterans may now be admitted to the Soldiers' Home at Waupaca. This is a state institution which was originally built for the care of Civil War veterans. It is now open to the soldiers of the Spanish-American War and also the World War.

* * *

Medical applicants must serve their regular interneship, the attorney general's office held in an opinion to the State Board of Medical Examiners. The attorney general's office declares:

"The statute as amended is quite clear and unambiguous. It provides that the applicant shall furnish a diploma from a reputable professional college. It also provides that applicants shall present satisfactory evidence of having completed a two years' college course in certain specified subjects, and further provides that if the professional college from which the diploma is presented does not require for graduation an interneship of at least twelve months in addition to a four year course, a certificate of completion of such interneship must be furnished. It is clear that the applicant is required to have completed an interneship of twelve months."

* * *

The attorney general's office in an opinion to Fond du Lac officials held that police are not entitled to witness fees. It also held that highway officers, if they are not authorized to serve processes, are not permitted to carry concealed arms.

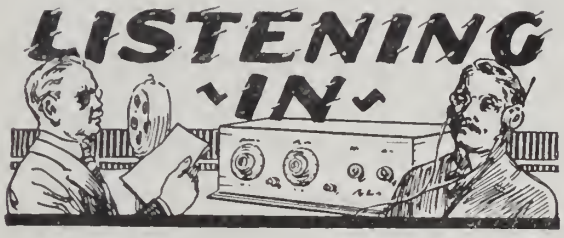
* * *

The State Department of Education has held that an application for a writ of mandamus to compel a teacher to reinstate a pupil who has been suspended or expelled, will not be issued by a court. Mandamus will not lie against a teacher but it will lie against the school board. The board only has power to expel or permanently suspend a pupil.

* * *

Plans for the enforcement of the state automobile driver's license law, enacted at the present session of the legislature, are being laid by the secretary of state with an estimate that nearly 2,000,000 persons will come under the new licensing provisions. The provisions go into effect January 1.

Application forms for the driver's licenses will be simple and licenses to drive cars will be denied only to persons under 16 and to those obviously possessing physical defects that would seriously handicap them in automobile operation. The main feature of the law is expected to be greater ease in preventing persons from driving automobiles after having been convicted of offenses such as driving while intoxicated or for reckless driving.



FAR-REACHING DECISION

That the question of a patient's susceptibility to the roentgen ray is a risk that the patient must assume and for which the physician cannot be held responsible, was the gist of an important opinion by the Wisconsin Supreme Court handed down in its last assignment for the summer. The case arose in Fond du Lac county circuit court where the lower court found a physician guilty of malpractice because of burning a patient's neck by the x-ray.

The court held that in such cases, which are not common, the person administering the treatment is no more liable than a surgeon who uses a knife, and if ill effects ensue through some unforeseen occurrence, and if the dosage administered is not excessive, and the principles of the art mastered in accordance with professional standards, and such standards followed, no damage may be recovered. The Supreme Court remanded the case with instructions to dismiss the complaint.

A SECOND DISMISSAL

The Supreme Court also overruled a $10,000 malpractice verdict against Dr. Frederick Mueller, Chicago. In this case it was found in the lower court that the physician had been guilty of malpractice in his treatment of an abcess in the hip joint. The Supreme Court found, however, that there was no competent evidence in this case to support the jury findings that the physician had either breached the duty which he owed or the obligation he undertook in rendering services as a physician.

HASTY LETTERS

During June a member of the State Society submitted a narrowly averted malpractice case to the Secretary. For some months this member had been treating an industrial accident case by methods considered proper by the physician. The insurance company concerned requested a consultation with their physician. In reporting his conclusions to the company, the consultant declared that he considered the then present line of treatment as "a little

worse than no treatment at all" and commented on "poorly applied bandages."

Further consultations supported the treatment followed and this case is mentioned to indicate how a hasty letter may well be the cause of a malpractice suit not founded upon fact. While we must consider the patient's interest as paramount to other considerations, this may well be accomplished without saying or writing that which may be interpreted as immediate cause for malpractice when, as a matter of fact, the physician concerned is not ready to make that charge.

THE DISTRICT MEETINGS

District meetings throughout the state, inaugurated so successfully a year ago, are again being scheduled. Such meetings offer a splendid opportunity for the members of one county to meet and become better acquainted with their fellow members of surrounding counties. Such meetings offer programs of unquestioned calibre and the prediction is ventured that they will become one of the greatest values in the building of Wisconsin Medicine.

OUR LAWS

Praise of Wisconsin's Basic Science Act was the keynote of the address of Dr. Edward Ochsner, Chicago, before the Clinical Hospital Congress in Milwaukee during June. Dr. Ochsner called upon the public generally to aid the profession to the end that this law should never be weakened.

The law was again praised by Dr. Franklin Martin, Director of the College of Surgeons, during June and no week passes but what officers of other states write to secure additional information.

SOCIETY RECORDS

New Members

McMahon, A. E., Glenwood City.
Mungar, G. C., Ellsworth.
Hess, J. S., Jr., Mauston.
Johnson, Willis L., Janesville.
Lawrence, Hans W., Janesville.
O'Connor, E. B., South Milwaukee.
Baur, E. F., 221 Wisconsin Ave., Milwaukee.
Kash, S. H., 230 Wisconsin Ave., Milwaukee.
Sutherland, J., Wis. Public Service Bldg., Oshkosh.
Pfefferkorn, E. B., Oshkosh Clinic, Oshkosh.
Ballard, James A., Hayward.
Arneson, Thomas, Almena.

Changes in Address

Juster, E. M., New Glarus, to Madison.
Meinert, A. E., Galesville, to Winona, Minn.
Helmes, L. O. Milwaukee, to The Schiek Clinic, Rhinelander.
Coon, W. W., Gays Mills, to Milton.

"Just a Little Different" is Eau Claire Promise for 86th Annual Meeting September 20-23.

Declaring that the Eau Claire session of the State Medical Society will be known as the meeting that was "different", chairmen of the committees are working to arrange a schedule that will provide the maximum in scientific programs and good entertainment.

Entertainment plans include the fourth annual golf tournament for the President's and Secretary's trophies together with a score of prizes for the runners-up; a public meeting followed by a smoker at the Elks' Club; alumni luncheons; the annual dinner and other features to include a complete program for the entertainment of the wives of the members. Dr. R. E. Mitchell, chairman of arrangements, announces that Eau Claire has just taken care of a meeting with 2,400 guests in attendance and that with the cooperation of the Chamber of Commerce and the hotels ample housing facilities are being arranged to care for an attendance of 1,000 members and guests.

"The hotels have pledged all their rooms for the days of our meeting," said Dr. Mitchell. "We will have the best of rooms for every member and guest in attendance. Next month we will announce a single center for all reservations and

The Water Street bridge. Eau Claire has sixteen bridges.

Eau Claire promises that no member will be disappointed. Special information booths, garage space, the latest 'dope' on the roads—all this and more will be available that every member may know the hospitality of Eau Claire and northern Wisconsin."

Entertainment plans for the wives of visiting members will include automobile rides, teas, luncheon, cards and a special performance at a local theatre.

Announcement of the preliminary scientific program will be made in the August issue of the Journal, according to Dr. H. M. Stang, chairman of the program committee. A special meeting of the Program Committee was held in Eau Claire late in June to formulate the final subjects for a

The State Teachers' College

Randall Park

program that will be of the greatest possible value to the entire membership.

While meetings of the House of Delegates will be held in the Eau Claire Hotel, all scientific sessions will be housed in Fournier's Academy, located just five blocks from the center of the city. The location was chosen because of the large and comfortable halls for both the sessions and exhibits, and because of the fact that the Academy location offers ample parking facilities and freedom from the noises of the city. Special luncheon facilities will be available close to the Academy for the convenience of the members.

The Eau Claire Country Club has been turned over to the State Society for the golf tournament on Tuesday, September 20th. At that time the members will compete for the two traveling cups with the permanent award prizes, together with the other prizes offered in tournament flights. Dr. E. G. Curtis, Eau Claire, chairman of the golf committee, will announce the opening of entries and the prizes in the August issue of the Journal. The prizes will be awarded following the Annual Dinner on Thursday evening, September 22nd.

HEART OF THE VALLEY

Eau Claire is picturesquely located on both sides of the Chippewa and Eau Claire rivers, which meet in the center of the city. The city is the geographic center of the Chippewa valley. With a population of over 24,000, Eau Claire is one of the few cities in the state which offer the advan-

The Eau Claire Hotel, where all sessions of the House of Delegates will be held

The Elks Club, where the Smoker and Annual Dinner will be held

Canoeing on Lake Hallie

tages of the city together with quick access to fishing, hunting and other outdoor sports. It is anticipated that many members will spend the week-end preceding or following the meeting in the many excellent fishing resorts nearby. Dr. R. E. Mitchell announces that full information on the lakes and resorts may be obtained by writing him at any time prior to the meeting.

A complete commercial-scientific exhibit will be held at the Academy building for the convenience of the members. Among those who will exhibit are the following:

DeShell Laboratories, Chicago.

H. G. Fischer Co., Chicago and Milwaukee.

Hanovia Chemical and Manufacturing Co., Newark, N. J.

Horlick's Malted Milk Company, Racine.

E. H. Karrer Company, Milwaukee.

Kremers-Urban Company, Milwaukee.

Medical Protective Company of Fort Wayne, Indiana.

Mellin's Food Company, Boston, Mass.

Victor Mueller Company, Chicago.

Pengelly X-Ray Company, Milwaukee and Minneapolis.

Physicians' and Hospitals' Supply Company, Minneapolis, Minn.

Pitman-Moore Company, Indianapolis, Indiana.

Roemer Drug Company, Milwaukee.

Saunders Publishing Company, Philadelphia, Pa.

E. R. Squibb, New York City.

Victor X-Ray Corporation, Milwaukee and Chicago.

University of Wisconsin, Medical Package Library Service.

Résumé and Status of Bills of Interest to Physicians; Assembly and Senate Action to July First Listed

AFFECTING MEDICAL LICENSURE

68A—Hinckley. The present law provides that a physician convicted of a crime in the course of his professional conduct shall have his license revoked. This bill provides that the court "may" do so instead of "shall," and further, should the license be revoked, empowers the court to restore the license.

Killed by Assembly; reconsidered 52-31; amendment introduced; re-referred to Committee on Public Welfare.

The amendment so changes the bill that when adopted the bill will then only provide that in cases where a physician's license has been revoked for a first offense, it may be restored by the Court upon written approval of the President of the State Board of Medical Examiners.

Substitute offered by State Medical Society clarifying and adding requirements. Substitute adopted by Assembly. Passed by Senate. Signed by Governor.

239A—Withrow. This bill is introduced by request of the State Board of Medical Examiners. It provides for an appropriation of $5,000 annually to the board for the purposes of law enforcement efforts.

Recommended for passage by Assembly Committee on Public Welfare. Advanced by Assembly 86-3. Referred to Joint Committee on Finance. Recommended for passage 13-0. Advanced by Assembly. Passed by Assembly 73-1. Recommended for killing by Senate Committee on Public Welfare, Senator Englund dissenting. Senate refused to kill 8-22. Passed by Senate 23-7. Vetoed by Governor.

416S—H. H. Smith. This is an eighteen-page bill enacting an entirely new State Narcotic Act. Proponents of the measure are federal narcotic officials. The bill would entwine the state law with the Harrison Narcotic Act (federal). The bill was full of objectionable features to physicians.

The State Medical Society proposed substitute amendment 1-S. This substitute amendment brings present State Narcotic Act to date and strikes out of the present act features objectionable to physicians.

Substitute amendment 1-S recommended for passage by Senate Committee on Education and Public Welfare. Passed by Senate. Passed by Assembly. Pending before Governor.

GENERAL HEALTH MEASURES

182S—Hunt. This measure provides that lye shall be labeled as poison and two antidotes listed on the label.

This is a uniform state bill fostered by the American Medical Association and the State Medical Society of Wisconsin.

Passed by Senate. Passed by Assembly. Recalled for corrective amendment. Amendment adopted. Signed by Governor.

470A—Assembly Committee on Public Welfare. This bill, introduced by request of the State Board of Health, aimed to make clear the fact that a violation of present State Quarantine Law was a misdemeanor, and provided penalties.

Chiropractors introduced amendment 1A to provide that they might attend cases of contagious diseases on the same basis as physicians.

Amendment 1A adopted in Assembly, 56-25. Bill as amended advanced 45-44. Refused to kill 26-39. Passed by Assembly 43-22. Recommended for killing by Senate Committee on Education and Public Welfare. Killed by Senate 13-5. Motion for reconsideration killed 18-8.

505S—Senate Committee on State and Local Government. This bill provides that the town chairman, village president, mayor, or chairman of the county board, can authorize temporary medical relief for a poor person "and liability for expenses so incurred shall be the same as though incurred by the board or council."

This bill was introduced at the suggestion of the State Medical Society.

Recommended for passage by Senate Committee on Education and Public Welfare. Passed by Senate. Passed by Assembly. Pending before Governor.

558S—Senate Committee on Judiciary. This bill appropriates to the State Board of Health $10,000 a year for the purpose of employing two state narcotic inspectors.

Killed by Senate.

635A—Assembly Committee on Municipalities. This bill provides that the secretary of the State Board of Health shall be a full-time officer "and shall not engage in the private practice of treating the sick for compensation." This bill writes into the law what is now the present practice.

Passed by Assembly. Killed in Senate.

RELATING TO INSANITY

156S—Senator Sauthoff. The main features of this bill are: (1) Denies subsequent re-examination of a person committed as insane for a period of six months from commitment and, (2) substitutes a jury of three physicians to decide question of sanity when such trial is demanded, instead of a lay jury, "each juror shall receive $15 as compensation."

Pending in Senate.

550S—Senator Hunt. The main features of this bill are: (1) Re-writes, at suggestion of Board of Control, the examination blank used by physicians in determining sanity and, (2) makes more certain that the state does not pay for maintenance of a person adjudged as insane whose estate is sufficient to pay for institutional care.

Passed by Senate. Passed by Assembly. Pending before Governor.

559S—Senate Committee on Judiciary. This bill, introduced at the suggestion of the State Medical Society, makes a jury permissive in insanity cases only upon decision of judge.

Pending in Senate.

560S—Senate Committee on Judiciary. This bill, introduced by the suggestion of State Medical Society, provides for licensing and inspection of private sanitariums and for commitment thereto, if desired, by relatives.

Killed in Senate.

561S—Senate Committee on Judiciary. This bill, introduced at suggestion of the State Medical Society, increases the fees for judge and examining physicians to $10 per day.

Killed by Senate.

Bill to Let Down Quarantine Bars Again Defeated; Governor Vetoes Appropriation to Oust Quacks

The committee on public welfare bill of the assembly which would have opened quarantined homes to anyone who called himself a "practitioner" and would have permitted any claimant to healing powers to treat contagious diseases was killed for the second time on reconsideration in the senate Tuesday, June 7. The upper house, which had previously killed the bill, refused the measure reconsideration, eighteen to eight.

The roll call follows: For reconsideration—Cashman, Gettelman, Keppel, Polakowski, Roethe, Ruffing, Schuman, and Titus.

Against—Barker, Blanchard, Boldt, Caldwell, Carroll, Daggett, Englund, Goodland, Hull, Johnson, Lange, Markham, Mehigan, Mueller, Sauthoff, Severson, Teasdale and White.

Senator William A. Titus, Fond du Lac, declared that the bill applied to a broad classification when it permitted everyone who called himself a "practitioner" to enter quarantined premises and said that while he would vote for a reconsideration he was opposed to the measure.

"A practitioner may be a dentist or a horse doctor," Senator Titus declared.

Senator Howard Teasdale, Sparta, declared that the bill had been a good one before the amendment was adopted. He explained that the original bill merely specified penalties for violations of the quarantine law, while the amendment opened the treatment of contagious diseases to everybody. This, he said, should not be permitted.

"I believe one of the outstanding associations of the state, the M. D.'s, try to control our legislature," Senator John C. Schuman, Watertown,

contended. "I don't see why chiropractors can't enter homes as well as doctors as long as they must take the same precautions."

Senator Irving P. Mehigan, Milwaukee, declared that the bill was one detrimental to the public health and said that all health officers are opposed to it.

"People who know nothing about the spread of disease should not be permitted to enter quarantined premises," Senator Teasdale said.

"Then why permit clergymen to enter quarantined places?" Senator Schuman asked.

Senator Mehigan replied that clergymen do not enter quarantined homes to treat the sick.

During the same week the Governor returned, without his approval, the Withrow bill appropriating $5,000 a year for the coming two years to the State Board of Medical Examiners. This bill, introduced at the request of the Board and supported by the State Society, would have provided funds for the continuance of a special investigator employed by the Board since last spring. The investigator was then employed on a surplus fund and the appropriation was to enable the Board to continue its efforts for a two year period. The Governor's veto follows:

VETO MESSAGE

"To The Honorable, The Assembly:

"I return herewith bill number 239, A., without my approval.

"The justification urged for the passage of this bill is that this sum of money is required to provide for the prosecution of quacks and illegal practitioners. It is not pointed out in what particular or why this should be presently necessary. No similar provision has been made in recent years. In order, therefore, for such an appropriation to be approved, some specific evidence of its present need, some evidence of change in conditions, should be presented before such an expenditure can be justified. This is especially true at a time when every effort is being made to cut down state expenditures.

"The counties of this state go to considerable expense in the employment of prosecuting officials who are ultimately responsible for the enforcement of any laws that any quack or any illegal practitioner may have violated. These officials must conduct these prosecutions for law violations. For the state, therefore, to appropriate an additional amount for this purpose is to duplicate this function and in all probability to waste a large part of the funds appropriated. A little cooperation from local practitioners calling the attention of the law violators to local prosecutors will do more to secure results at less expense than special investigators can accomplish by traveling all over the state seeking information in communities where they are strangers.

"The courts are open in every county to any member of any medical society to complain of any illegal and improper conditions and the district attorney, if he performs his functions, will prosecute such cases.

"If he fails, the method of handling such a situation is not by appropriating money to another organization to supplant him in some limited activity, but to follow the course contemplated by the statutes, and bring complaint for his removal.

"For this reason, in my judgment the expenditure of this money is entirely unnecessary.

Respectfully submitted,

FRED R. ZIMMERMAN,

Dated: June 1, 1927. Governor."

Dr. A. J. McDowell, Soldiers Grove
Only physician member of the 1927 Wisconsin Legislature.

RELIEF BILL PASSES

During the last of June the Assembly gave final passage to the Senate bill on the subject of emergency relief to the poor. This bill, introduced at the suggestion of the State Society, applies only to those counties which have no county-wide organized system for the care of the poor. In counties not so organized the bill permits the town, village or county board chairman to authorize a physician to attend poor relief cases. Formerly such authority had to come from the respective board in session before the physician's bills were allowed for payment. The bill is now pending before the Governor.

The Senate also passed and the Governor signed the bill by Assemblyman Hinckley, Milwaukee, providing a means whereby a physician whose license has been revoked may secure its restoration. The original Hinckley bill provided such an easy method of restoration as to make its opposition by the State Society a requirement. Following its death the substitute was worked out by the author and the representatives of the Medical Board and State Society. The substitute bill, now a law, provides the following method (new law in italics):

"(147.20) (4) When a license or certificate is revoked, no license or certificate shall be granted thereafter to such person. *Any license or certificate heretofore or hereafter revoked may be restored by subsequent order of the trial court, but only after a first revocation, upon notice to the district attorney who prosecuted, or, in the event of his disability, his successor in office, upon written recommendation by the president of the State Board of Medical Examiners, and upon findings by the court that the applicant for restoration of license or certificate is presently of good moral and professional character and that justice demands the restoration.*"

LYE BILL SIGNED

Governor Zimmerman also gave approval during June to the model state lye bill promoted by the American Medical Association. In brief, this bill provides that lye and lye caustic preparations sold for household use shall be labeled as "poison" in large type and that at least one antidote be printed on the label. The purpose of the bill is to prevent the accidental swallowing of lye and like solutions by children who mistake the solutions for water. It is believed that the new label will warn mothers and thus prevent the careless handling of these caustic substances.

The bill was first suggested by Dr. Chevalier Jackson of Philadelphia and in Wisconsin its passage was made a part of the 1927 legislative program by the last house of delegates. Drs. Nelson M. Black, Milwaukee, and Roy Barlow, Madison, accomplished much of the effort necessary to bring the dangers of these substances before the legislature. The new law becomes effective on January 1st next.

PHYSICIAN'S TESTIMONY

Senate Bill No. 281, relating to testimony of physicians and surgeons, was finally concurred in by the Assembly on June 24, in substitute form. It is now pending before the Governor.

The original bill was proposed by the Board of Circuit Judges, and was virtually a complete repeal of the privilege of the patient to have confidential information given his physician protected against disclosure. The bill provided for the privilege only in case the court should decide that the disclosure would tend to degrade the patient or his memory. Thus in all cases disclosure would have to be made to the court, and be more or less public. The bill also provided that the bringing of any action by the patient or his representative in which the knowledge of his family physician should be material, should be a waiver of even the foregoing limitation. The bill also, in something of a reversal of its apparent intent, placed upon the physician in a civil malpractice suit a limitation not there before, that he could not make a disclosure of such information unless the plaintiff had first given evidence relating thereto.

The original bill was opposed by the representatives of the State Medical Society, at a joint hearing of the Judiciary Committees of the Senate and Assembly. A conference was later held between representatives of the judges and of the society, and the substitute which was passed was assented to.

The substitute retains the absolute privilege, with four specific exceptions:

(1) Trials for homicide. Here the public interest may require the physician's testimony to convict a felon, and the patient, it can be presumed, would have desired to have the testimony given.

(2) In lunacy inquiries. Here again an important public interest enters.

(3) Malpractice actions. Here the patient himself puts directly in issue his transactions with his physician.

(4) With the express consent of the patient, or in case of his death or disability, of his legal representative or other person authorized to sue for personal injury, or of the beneficiary of a policy on his life, health or physical condition. The new feature here is the insurance beneficiary, where the patient, it may be presumed, would have desired the testimony to be given.

The original bill would have destroyed the privilege that is now generally understood by the public, and have thrown open the most confidential relations between physician and patient for the benefit of private litigants, even when the patient had no interest in the litigation.

This privilege of the patient is essential to that full disclosure necessary to afford the physician the fullest opportunity to protect the health of his patient and the public. When the public came to realize that such confidential disclosures might be dragged into court and subjected to the gaze of the curious and the malicious, a reticent tendency would be increased, and the health of patients and the public would suffer accordingly.

The substitute retains the privilege, and confines the exceptions to definite instances of public interest and cases wherein the wish of the patient, which he is unable to express, ought to be carried out.

A. M. A. Delegates Consider Important Questions; Dr. Rock Sleyster Re-Elected Trustee

At the first meeting of the House of Delegates at Washington, May 16, the speaker, Dr. F. C. Warnshuis, urged continued attention to the problems of nursing education and nursing service in the United States. He suggested an attempt to solve the question of the requirements, qualifications and standards for a capable, competent surgeon and a means to aid the public in making such an identification. He also urged state licensure and special hospital legislation as a means for protecting the public against poor and incompetent institutions.

The president of the association, Dr. Wendell C. Phillips, urged continuous attention to the education of the public in matters of health. He suggested a proper system of censorship to safeguard medical publicity. He again recommended consideration of the restrictions placed on physicians in the prescribing of alcoholic liquors.

The president-elect, Dr. Jabez N. Jackson, urged new attention to the problems of medical ethics, and the preparation of a manual which would make clear both to the profession and to the public the intent of the "Principles of Medical Ethics."

The president of the association appointed a committee, consisting of Drs. Ray Lyman Wilbur, Rock Sleyster, G. E. Follansbee, Harlow Brooks and William Allen Pusey to act on public responsibility, having to do with the relationship of the medical profession to the public.

On recommendation of the Judicial Council, the opinion was adopted that all articles of an educational nature on medical or health subjects intended for the lay press or lay audiences should give expression to the consensus of opinion of the medical profession rather than to personal views, and that such articles should appear preferably under the auspices of the American Medical Association or of one of its component county societies or constituent state associations.

REPORT ON MEDICAL EDUCATION

In considering the report of the Council on Medical Education and Hospitals, the House of Delegates adopted the report of its reference committee. This committee considered as overoptimistic the views of the council that the present medical schools are adequate to supply places for those wishing to enter a medical school. The reference committee believed that the Council on Medical Education might devote more attention to the problems of the supply of physicians and the question of medical care in rural districts, to the preparation of a statement on the defects in the present situation and to similar subjects.

The reference committee considered it necessary that the present curriculum be reduced materially and that any consideration of a new curriculum should give special attention to the training of general practitioners, with brief courses in the more important specialties. The recent decision of the council to recognize as suitable for internship only hospitals in which there is a minimum percentage of necropsies was approved and recommended.

INVESTIGATION OF HEROIN

The reference committee on legislation and public relation requested the Board of Trustees of the American Medical Association to have another in-

vestigation of the use of heroin made by the Council on Pharmacy and Chemistry in conjunction with some of the scientific sections.

EVALUATION OF REMEDIES

It was recommended that the association condemn as unwise and futile any attempt to evaluate a therapeutic agent by legislative fiat, referendum, popular vote or any similar method. The conclusion was adopted that such evaluation can be made only by the investigation and decision of experts.

DISASTER RELIEF

A consideration of the report of the committee on disaster relief resulted in the adoption of a recommendation that the American Medical Association urge constituent associations and component societies that have not already established disaster relief committees to do so as soon as possible.

MORTALITY STATISTICS

It was urged by the adoption of a report of the reference committee on hygiene and public health that the attention of the United States Census Bureau be called to the impossibility of comparison of statements on maternal mortality of the various nations and that the bureau be urged to secure a strictly uniform definition of maternal mortality by the bureaus of vital statistics of various nations.

COSMETICS

A resolution urging Congress to enact a law to control the manufacture, distribution, sale and commercial use of toilet preparations for preserving and enhancing personal beauty was referred to the Board of Trustees for action.

EDUCATION OF SURGEONS

The reference committee on the speaker's address commended the section having to do with the duty of the American Medical Association to standardize and elevate the practice of medicine and surgery within and without hospitals through its own organization, but not through legislative or other agencies.

APPOINTMENT OF DELEGATES

The reference committee urged that state societies appoint delegates in time to permit the speaker of the House of Delegates to announce the reference committees thirty days in advance of the session, so that these committees might give adequate attention to the various reports of officers and councils before the time of the session.

HEALTH CONFERENCES

The importance of health conferences was recognized and attempts to reduce the duplication of efforts in various fields were encouraged.

CONTRACT PRACTICE

The report of the Judicial Council of the American Medical Association to the effect that there were both ethical and unethical contracts possible, and that each contract must be judged on its own merits was approved by the committee and adopted by the House of Delegates.

CHARGES FOR SERVICES TO INSURANCE AND INDEMNITY COMPANIES

A resolution to the effect that physicians were not under any obligation to provide information to insurance or indemnity companies unless paid the usual fees charged for similar services to private patients was approved and adopted by the House of Delegates.

PLACE OF NEXT ANNUAL MEETING

The Board of Trustees was asked to investigate places for holding the next annual session and to present its approval of two or more cities which, on investigation, have been found to possess ample facilities. The Board of Trustees has authority to change the place of holding the session if for any reason it is deemed advisable.

INCOME TAX DEDUCTIONS

A resolution requesting the promotion of an amendment to the revenue bill relating to income tax, which gives the individual a right to deduct from his income tax the expenses of medical treatment for himself and family was referred to the Board of Trustees, with the suggestion that they in turn transmit it to constituent state societies for action.

NURSING EDUCATION

Reports of the various committees on nursing education were received by the House of Delegates, and it was recommended that the American Medical Association give support in the work of the committee on grading of nursing schools and share in its financial program. The Board of Trustees appropriated the sum of $5,000 for one year towards this end.

THE PHYSICIANS' HOME

A special committee reported on the need of a physicians' home. The committee recommended that the secretary of the association be requested

to secure full information in regard to what is now being done by the profession for aged and incapacitated physicians, in various states and cities, so that other states or component societies may take measures to afford relief for dependent, worthy physicians, their widows and their orphans who may be in need. It was recommended that the secretary make a report on this matter at the next annual meeting. The committee was convinced that the need for a national home is not sufficient to warrant the American Medical Association in establishing, managing and sustaining a home.

COLLABORATION WITH HEALTH OFFICERS

Collaboration between physicians and health officers was urged as the only method of meeting the public health situation for the good of the profession and the public.

TRACHOMA AMONG INDIANS

The American Medical Association was urged to continue its affiliations with all the activities of the United States government of the work being done by the national committee for the prevention of blindness for the elimination of trachoma among Indians.

LEGISLATION FOR COORDINATING GOVERNMENT HEALTH ACTIVITIES

The House of Delegates reaffirmed its approval in principle of the Parker bill, coordinating the health activities of the federal government under the direction of the United States Public Health Service. It also adopted the report of the reference committee recommending approval of the Ransdall bill, appropriating $10,000,000 to establish a national institute of health under the control of the Surgeon-General of the United States Public Health Service.

DISABLED EMERGENCY MEDICAL OFFICERS

The House of Delegates reaffirmed its favorable action of 1922, requesting the passage of the Bursum bill, which relates to the retirement of disabled emergency army medical officers on a parity with all other classes of disabled officers of the World War now on the retired list.

MEDICINAL LIQUOR

The report of the reference committee of the House of Delegates to the effect that hereafter the House of Delegates shall not pass any resolution pertaining to the therapeutic value of anything and that no committee report empowering any such resolution shall hereafter be presented until it has been considered by the Council on Scientific Assembly and the Council on Pharmacy and Chemistry was adopted. Recommendation was made that the special committee on alcoholic liquors be continued and be directed to cooperate in preparing a bill to be presented to Congress correcting the unfortunate provision of the Volstead Act limiting the amount of alcohol used, and providing such regulations as will permit doctors to prescribe whatever amounts of alcoholic liquors may be needed for their patients, and subject to such reasonable restriction as may be thought wise and best after a conference with the head of the Prohibition Department.

It was also urged that the American Medical Association declare its adherence to the principle that legislative bodies composed of laymen should not enact restrictive laws regulating the administration of any therapeutic agent by physicians legally qualified to practice medicine.

A supplementary report of the Judicial Council recommended that "Every resolution presented relating to the alcohol question shall be referred to the Board of Trustees for investigation." The recommendation was adopted by the House of Delegates.

CAUSTIC POISONS

The House of Delegates approved the resolution extending to members of Congress the thanks of the American Medical Association for passing the Caustic Poison Act in 1927.

FORM LETTERS ON PERIODICAL PHYSICAL EXAMINATION

A resolution asking the Board of Trustees to prepare approved forms of letters or literature which may be sent out by county medical societies to the public to promote the value of periodic health examinations and information that the examinations can be made and records kept by qualified physicians who are members of the American Medical Association, in this manner helping to circumvent the harmful advertising activities of commercial agencies dealing with periodic health examinations, was endorsed by the reference committee and adopted by the House of Delegates.

CONTRACEPTION

A resolution recommending the alteration of existing laws, wherever necessary, so that physicians may legally give contraceptive information to their patients in the regular course of practice was referred to the Board of Trustees of the Association.

HEALTH HAZARDS IN INDUSTRY

The resolution petitioning Congress to make possible an increase in the personnel and resources of the United States Public Health Service in order that the service may extend its activities in the field of industrial hygiene was referred to the Board of Trustees.

AMENDMENTS TO THE BY-LAWS

Notices of proposed amendments to the by-laws: (1) defining the powers of the Judicial Council; (2) defining the legislative powers of the association and the right of the House of Delegates to expel members or fellows on recommendation of the Judicial Council; (3) a resolution changing the members of the Council on Medical Education and Hospitals was presented and must lie over to 1928 for action.

WOMAN'S AUXILIARY

A motion that the House of Delegates request the Board of Trustees to appoint a liaison committee between the American Medical Association and the Woman's Auxiliary was adopted.

ELECTION OF OFFICERS

In the election of officers, Dr. William S. Thayer of Baltimore was elected president of the association; Dr. Charles A. Elliott of Chicago, vice-president; Drs. Olin West, secretary, and Austin A. Hayden, treasurer, were reelected, as were also the speaker, Dr. Frederick C. Warnshuis of Grand Rapids, Mich., and vice-speaker, Dr. Allen H. Bunce of Atlanta, and the trustees, Drs. Edward B. Heckel of Pittsburgh and Rock Sleyster of Wauwatosa, Wis.

The president, Dr. Jabez N. Jackson, made the following nominations to appointments on the various councils: For the Judicial Council, Dr. Donald McCrae, Jr., Council Bluffs, Iowa, and Dr. Frank Cregor of Indianapolis, to succeed Dr. Thayer; for the Council on Medical Education and Hospitals, Dr. Emmett P. North, St. Louis; for the Council on Scientific Assembly, Dr. Frank H. Lahey of Boston. These nominations were confirmed.

FORMER ILLINOIS DOCTORS

Doctors who lived formerly in Illinois, or who are descendants of pioneer physicians of the "Illinois country", will hear with interest that Volume One of the "History of Medical Practice in the State of Illinois" is ready for delivery.

The history has been written under the supervision of a committee appointed by the Illinois State Medical Society as a commemoration of its seventy-fifth anniversary but more especially to make a living tribute to those valiant men of the medical profession who played so able a part in the exploration, settlement and development of the Illinois country.

In this first volume of the history are set down events from the earliest available knowledge of conditions in the Illinois country, along through the days of the Aborigines, and commencing with the actual records when, in 1673, Father Marquette had medical attention in Chicago, up until the year 1850.

In the second volume (now in preparation) narration continues up until the present time. Future years will bring other volumes, so that this history will be an ever virile monument to the men and incidents whom it would honor.

Research of years resulted in an opulent supply of material from which to compile this history and has evidenced to an almost unbelievable degree the vital part played by physicians in every angle of the exploration, settlement and development of a country that is one of the richest and most influential sections of the richest country in the world.

It must be remembered that originally the Illinois country encompassed a territory far greater than the area now known as the states of Illinois, Wisconsin, Indiana, Missouri, Kentucky and Iowa, as well as what is now Illinois, and even some sections of Ohio fell into that primitive epitome of the Illinois country. In the southern part of the state it was well into the nineteenth century before Missouri and Illinois ever acknowledged the natural divorce of interests made by the Mississippi River. Because of this, naturally enough, close interest in this history extends to physicians or to their descendants in practically every state in the Mississippi Valley or contiguous thereto.

Rare maps, unusual personal memorabilia and rare discretion in compilation make this history of unique interest to doctors everywhere and to many laymen.

This history of medical practice in the state of Illinois embodies in the course of its narration an interesting and illustrated digest of the early efforts of white settlers in Illinois, with specific allusion to the share in these tasks performed by medical men. Included are portraits of rare interest, reproductions of historic documents, excerpts from diaries, personal letters, human reminiscences of days fraught with peril, filled with hope, and not devoid of humor, through a period of about 250 years. From the days of the "Chirugeon" who attended Pere Marquette, through the massacres at Fort Dearborn, the years of Indian raids, down with the circuit-riding "saddle-bag" doctors, to these days of radium and radio, this history marches. Attics, family albums, safe deposit vaults, and state records have been ransacked to produce the material needed for this chronicle. Illinois holds today the honor of being the world's medical center. Progressive steps of this achievement, and its contributive factors such as hospitals, asylums, sanitariums and allied institu-

(Continued on Page 390)

THE JOURNAL BOOK SHELF

Physiotherapy. Theory and clinical application. By Harry Eaton Stewart, M. D., President-elect American Academy of Physiotherapy, director New Haven School of Physiotherapy. Paul B. Hoeber, New York.

Electrothermic Methods in Neoplastic Diseases. (Desiccation and Coagulation.) Designed as a practical handbook of surgical electrotherapy for the use of practitioners and students. By J. Douglas Morgan, M. D. Illustrated with 36 engravings. Price, $2.50. F. A. Davis Company, Philadelphia, 1926.

Health Supervision and Medical Inspection of Schools. By Thomas D. Wood, M. D., college physician, adviser in health education, and professor of physical education, Teachers College, Columbia University, and Hugh G. Rowell, M. D., physician to the Horace Mann School, lecturer and assistant physician, Teachers College, Columbia University. Octavo of 637 pages, with 243 illustrations. Cloth, $7.50 net. W. B. Saunders Company, Philadelphia and London, 1927.

Pseudo-Appendicitis. A study of mechanical syndromes of the right lower quadrant simulating appendicitis by Thierry de Martel, surgeon to the Paris Hospital, and Edouard Antoine, attending physician to the Paris Hospital. Translated from the French by Dr. James A. Evans, formerly assistant radiologist, St. Antoine Hospital, Paris, France. Published in 1925 by the F. A. Davis Company, in cloth binding, 201 pages, with 41 engravings.

The Diseases of Infants and Children. By J. P. Crozer Griffith, M. D., Prof. of Pediatrics in the Graduate School of Medicine of the University of Pennsylvania, and A. Graeme Mitchell, M. D., Prof. of Pediatrics, College of Medicine, University of Cincinnati. Second edition, reset. Two octavo volumes totaling 1,715 pages with 461 illustrations, including 20 plates in colors. Cloth, $20.00, net. W. B. Saunders Company, Philadelphia and London.

The Fifth Avenue Hospital Clinics. First series, based on the material from the semi-monthly staff meetings. Illustrated. Paul B. Hoeber, Inc., Publishers, New York City, MCMXXVII. Price, $5.00.

Harelip and Cleft Palate Cheiloschisis, Uranoschisis and Staphyloschisis. By Matthew N. Federspiel, D. D. S., M. D. The C. V. Mosby Company, St. Louis.

Examination of Children. By clinical and laboratory methods. By Abraham Levinson, M. D., Associate in Pediatrics, Northwestern University Medical School. Second edition, with 85 illustrations. Price, $3.50. C. V. Mosby Company, St. Louis, 1927.

Nineteenth Annual Conference of the American Association of Medical Milk Commissions and The Certified Milk Producers' Association of America, May 25-26, 1925, Chalfonte-Haddon Hall, Atlantic City, N. J.

Management of the Sick Infant. By Langley Porter, M. D., Prof. of Clinical Pediatrics, University of California Medical School, and William E. Carter, M. D., Instructor in Pediatrics, University of California Medical School, San Francisco. Third revised edition. Illustrated. Price, $8.50. C. V. Mosby Company, St. Louis, 1927.

Should We Be Vaccinated? A survey of the controversy in its historical and scientific aspects. By Bernhard J. Stern, Instructor of Sociology, Columbia University. Price, $1.50. Harper & Brothers, Publishers, New York and London, 1927.

Obstetrics for Nurses. By Joseph B. DeLee, M. D., Prof. of Obstetrics, Northwestern University Medical School, Chicago. Eighth edition, revised. Pages 635, with 266 illustrations. Cloth, $3.00, net. W. B. Saunders Company, Philadelphia and London, 1927.

A Manual of Gynecology. By John Osborn Polak, M. D., Prof. of Obstetrics and Gynecology, Long Island College Hospital; Prof. of Obstetrics in the Dartmouth Medical School. Third edition, thoroughly revised. Illustrated with 145 engravings and 12 colored plates. Price, $5.00. Lea & Febiger, Philadelphia, 1927.

BOOKS RECEIVED FOR REVIEW

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1926. With comments that have appeared in The Journal. Cloth, $1.00. Pp. 73. American Medical Association, 1927.

New and Nonofficial Remedies, 1927. Contain descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1927. Cloth, $1.50. Pp. 473, XLVII, Chicago. American Medical Association.

Surgical Clinics of North America. Vol. VII, No. 2, Cancer Number, April, 1927. Pp. 231 with 113 illustrations. Per clinic year (February, 1927, to December, 1927). Paper, $12.00; Cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

New Illustrated Catalogue. Describes and illustrates more than 250 medical books. W. B. Saunders Company, Philadelphia and London.

City Health Administration. By Carl E. McCombs, M. D., National Institute of Public Administration and New York Bureau of Municipal Research. The Macmillan Company, New York, 1927.

Lectures on Internal Medicine. Delivered in the United States in 1926. By Knud Faber, M. D., Prof. of Internal Medicine, University of Copenhagen, Denmark. With 43 figures and charts. Price, $3.00. Paul B. Hoeber, New York, 1927.

How to Make the Periodic Health Examination. A manual of procedure. By Eugene Lyman Fisk, M. D., Medical Director, Life Extension Institute and J. Ramser Crawford, M. D., Assistant Medical Director, Life Extension Institute. The Macmillan Company, New York, 1927.

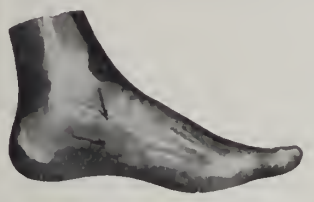
Heart and Athletics. Clinical researches upon the influence of athletics upon the heart. By Dr. Felix Deutsch, Privat-docent in Internal Medicine at the University of Vienna and Dr. Emil Kauf, Assistant at the "Heart Station" in Vienna. English translation by Louis M. Warfield, M. D., Former Professor of Internal Medicine, University of Michigan. Price, $2.50. C. V. Mosby Company, St. Louis, 1927.

Practical Lectures on the Specialties of Medicine and Surgery. Delivered under the auspices of The Medical Society of the County of Kings, Brooklyn, New York Second series, 1924-1926. With 110 illustrations. Price. $7.00. Paul B. Hoeber, New York, 1927.

Mortality Statistics, 1924. Twenty-fifth annual report. Price, $2.25. U. S. Government Printing Office, Washington, D. C., 1927.

Being Well Born. An introduction to heredity and eugenics. By Michael F. Guyer, Prof. of Zoology, The University of Wisconsin. Illustrated. Bobbs-Merrill Company, Indianapolis.

DO NOT OVERLOOK THE FEET IN YOUR EXAMINATION



The symptoms of corns, callouses, bunions, burning, aches, pains, hammer toes, flat feet, and Morton's toe point to the falling of one or more of the arches of the feet. The x-ray picture above shows the cuboid bone dropped down along its inner border; and since this bone is the outer edge of the Posterior Transverse Arch, it proves that this, the main arch of the foot, has fallen.

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Practical Otology. By Morris Levine, M. D., Associate Professor of Otology, New York Post-Graduate Medical School and Hospital. Illustrated with 145 engravings and 3 colored plates. Price, $5.50. Lea & Febiger, Philadelphia, 1927.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 153 E. Wells Street, Milwaukee, Wisconsin. These new books will be loaned for an inspection period only.

Dental Materia Medica and Therapeutics. With Special Reference to the Rational Application of Remedial Measures to Dental Diseases. A textbook for students and practitioners. By Hermann Prinz, D. D. S., M. D., Prof. of Materia Medica and Therapeutics, The Thomas W. Evans Museum and Dental Institute School of Dentistry, University of Pennsylvania. Sixth edition, enlarged and revised according to the United States pharmacopeia, tenth decennial revision. Price, $6.00. C. V. Mosby Company, St. Louis, 1926.

A new edition of this well known book will be welcomed by the dental and medical profession. This being the sixth edition, it shows considerable changes in comparison to the fifth edition, which was issued about nine years ago. One of the most striking and interesting chapters on "Preparations for the mouth and teeth" will be found of particular interest to those who wish to know more about tooth pastes, powders and mouth washes. No dentist can well afford to be without this book if he uses local anesthesia in his practice. This book contains 72 pages devoted to local anesthesia, and the illustrations are excellent and very instructive. A number of new drugs have been added, and most of the chapters have been extensively altered.—M. N. F.

Exodontia. A textbook of Exodontia, Oral Surgery and Anesthesia. By Leo Winter, D. D. S., Prof. of Oral Surgery, New York University College of Dentistry. With 329 illustrations. Price, $7.50. C. V. Mosby Company, St. Louis, 1927.

This book contains 28 chapters dealing extensively with the extraction of teeth and minor surgery of the mouth, including a very exhaustive report on general and local anesthesia as applies to dental operations. The book is very well illustrated, and is very instructive in the technic for the removal of impacted teeth. This book should be in the library of every dentist who is called upon to do extraction of teeth and minor surgery of the jaws.—M. N. F.

A Text Book of Medicine. By 130 American authors. Edited by Russell L. Cecil, M. D., assistant professor of Clinical Medicine, Cornell University, Medical School, New York. Octavo of 1,500 pages, illustrated. Cloth, $9.00 net. W. B. Saunders Company, Philadelphia and London.

A volume of 1,449 pages written by one hundred and thirty authors does not lend itself to a comprehensive review. In going over the book one is impressed with the brevity and sketchiness of many of the articles. The editors have attempted an impossible task in the reviewer's opinion. The whole subject of medical disease, including diseases of the nervous system, is compressed into one volume. It is tabloid in its general contents. In spite of this obvious defect the book is a mine of information. All the articles, even the brief ones of a page or less, are written by those who can speak with authority upon the particular subject.

We wish some of the articles could have been expanded more. Most books suffer from a plethora of words. This book goes to the other extreme and suffers from a paucity of words.

Yet it is a splendid book and the editors are to be congratulated upon condensing so much information into one volume.

The book is well indexed so that one has no difficulty in finding the subject for which he is looking.

The paper is good, the print clear and distinct. We have no hesitancy in recommending this book to students and practitioners as an excellent compendium of medicine as we know it today.—L. M. W.

Medical Clinics of North America. Vol. X, No. 5, Boston number, March, 1927. Octavo of 311 pages with 34 illustrations. Per clinic year, July, 1926, to May, 1927. Paper, $12.00; cloth, $16.00. W. B. Saunders Company, Philadelphia and London.

This Boston number is unusually interesting. To enumerate all the titles would take too much space, but when there are articles by Minot, Talbot, Joslin, Morse, Roger there are articles by Minot, Talbot, Joslin, Morse, Roger Lee, Christian and others, one is sure to find much which is stimulating. The reviewer has seen most of these "Clinics", hence he feels competent to say that this one is the best he has read for quite a while, and it deserves a place in the library of every doctor interested in diagnosing and treating his patients.—L. M. W.

Diseases of the Digestive Organs. With special reference to their diagnosis and treatment. By Charles D. Aaron, M. D., Prof. of Gastro-Enterology and Dietetics in the Detroit College of Medicine and Surgery. Fourth edition, thoroughly revised. Illustrated with 174 engravings, 70 roentgenograms and 13 colored plates. Price, $11.00. Lea & Febiger, Philadelphia, 1927.

The reviewer has had the opportunity of seeing the three previous editions of Dr. Aaron's book and so has some grounds for comparison with the present fourth edition. He can say with all sincerity that this is a different book. The others were just books on diseases of the digestive organs. This is something more than an ordinary book. Dr. Aaron has evidently gone over his old material with great care, has culled here and there, has added much that is of recent date, and consequently the book gives the reader the impression of a finished product.

The scope of the book, including the mouth, liver, bile ducts, pancreas and intestines, is large but the author has included all the important information upon these subjects. The descriptions of the symptoms, the laboratory tests, the physical signs and treatment are done in a clear, easily flowing style. This cannot be said of all such books

Beginning with a chapter on "The Physiology of Digestion", the author takes up in separate chapters the exam-

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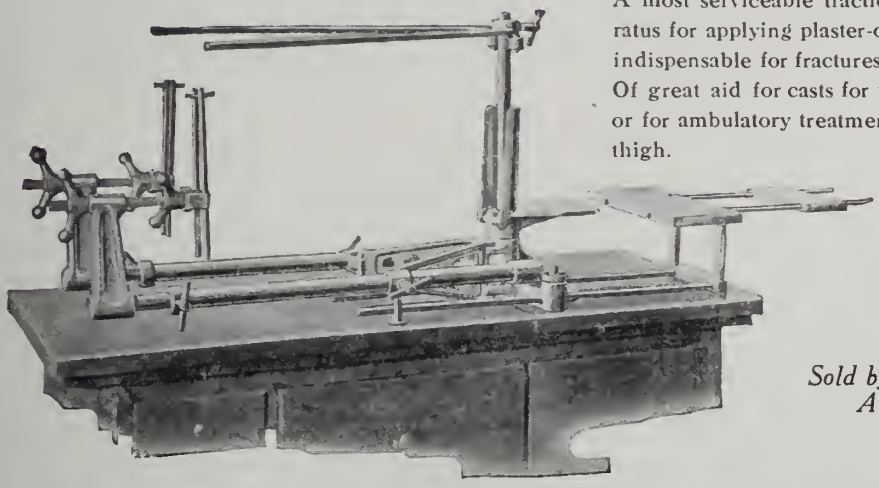

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ination of the stomach contents, the duodenal contents and the feces. Then there is a chapter on roentgenray examination, one on diet in gastric diseases, one on diet in intestinal diseases and one on lavage of the stomach. He discusses massage, electricity, hydrotherapeutics and mineral waters in two chapters. Then he deals with treatment. These make up the first thirteen chapters, 285 pages. From Chapter XIV to Chapter LIV, inclusive, he takes up in order the diseases of the digestive organs from the mouth to the anus.

Dr. Aaron has given us a splendid book. The most important feature to the reviewer is the sanity, the freedom from fads. The illustrations are excellent, many are in color and show strikingly the results of the various laboratory tests. The publishers are to be congratulated on their book-making.

This book can be highly recommended.—L. M. W.

New and Nonofficial Remedies, 1927, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1927. Cloth. Price, postpaid, $1.50. Pp. 473 XLVII. Chicago. American Medical Association.

The appearance of the annual edition of New and Nonofficial Remedies is looked upon as an event among all those interested in drugs and their therapeutic use. The text is so carefully scrutinized and revised each year by the various members of the Council on Pharmacy and Chemistry that each issue is essentially a new book, a safe guide to the frontier that lies between the official drugs and the latest preparations launched by the pharmaceutical manufacturers.

The mechanism of the book is excellent: each preparation is classified, and each classification is preceded by a general and critical discussion of the group by one who is an authority on the subject; there is an exhaustive index not only to the contents of the book, but also, separately, to the literature concerning the host of preparations that the Council has found unacceptable for inclusion. A glance at the book shows that the most important single revision this year is that of the general article on Lactic Acid-Producing Organisms, which has been radically revised and rewritten to show the present status of therapy in this field. Further perusal shows that many preparations have been omitted. The preface explains that many of these have been omitted because the manufacturers or distributors have not presented evidence to demonstrate their continued eligibility. Some have been omitted because they have become official articles by inclusion in the tenth edition of the U. S. Pharmacopeia; such articles, when marketed under the pharmacopeial name or synonym, and without special claims, do not require description in New and Nonofficial Remedies.

Among the preparations newly admitted to the book are: Isacen, a product related to phenolphthalein; Ipral, a barbital hypnotic; a cod liver oil concentrate having a definite vitamin A and vitamin B potency; and three erysipelas streptococcus antitoxin preparations.

New and Nonofficial Remedies is indispensable to any physician who prescribes drugs. It contains information about medical products which cannot be found in any other publication.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1926. With comments that have appeared in The Journal. Cloth. Price, $1.00. Pp. 73. Chicago: American Medical Association, 1927.

Those who are interested in the work of the Council on Pharmacy and Chemistry, and this includes all who have to do with the therapeutic use of drugs, look forward each year to the volume which gives the reasons for the Council's rejection of the preparations found unacceptable for inclusion in New and Nonofficial Remedies. These reasons are given in the Annual Reprint of the Reports of Council on Pharmacy and Chemistry; in addition, the book gives the reasons for the omission of certain preparations from New and Nonofficial Remedies during the year, and contains several special reports of a general nature authorized by the Council for publication.

Reports are given on the following articles found not acceptable for New and Nonofficial Remedies: Allonal, Animasa, three benzyl benzoate preparations, Ceanothyn, Cresog, Firma Chloro, Idozan, Malt Nutrine, Murarsenide, Naftalan, Neo-Reargon, Nontox, Numoquin, Oleosolution, "Pabst Extract—The 'Best' Tonic," Phenoseptine Cones and Phenoseptine Powder, Pollen Antigen Spring Type-lederle, Rad-X-Solution A and Rad-X-Solution B, Robes' Anti-rheumatic Injection, Sodium Methylarsenate (De Marsico), Ster-Alco, Sulcitacium, Tetradol, Thymo-Borine, Toxivi, Toxok, and Triophos. Besides these there are reports on a number of articles that have been omitted from New and Nonofficial Remedies.

The volume also contains the following special reports of current interest to physicians: a report on the status of bacillus acidophilus and bacillus bulgaricus therapy, on the basis of which the N. N. R. article on Lactic Acid-Producing Organisms has been revised and rewritten; a report dealing with the esteem in which antistreptococcus serum is now held by leading surgeons, gynecologists and obstetricians, prepared by Dr. Emil Novak on the basis of the answers to a questionnaire sent to representative members of these groups; and a preliminary report on the status of the new drug, Ephedrine.

FORMER ILLINOIS DOCTOR

(Continued from Page 385)

tions and medical colleges are set forth in detail, both pictorial, documentary and narrative. In brief, this account epitomizes the almost unequalled growth of a community whose economic wealth is paralleled by its public health. Personal data of the men, of the organizations, including pioneer army and navy physicians and surgeons and local, county and district societies, schools and hospitals, as well as of the Illinois State Medical Society itself; various internationally famous medical discoveries made by Illinois men; the state's contribution to the world of research; medical libraries and periodicals existent in Illinois; campaigns for medical protection against enemies of public health; details of the various Medical Practice Acts; state sanitation from the notable drainage canal and the supervision of food supplies, vital statistics; meetings, officers, policies and finances of the State Society—all this and more in accurate transcription make

The Wisconsin Medical Journal

Volume XXVI Milwaukee, August, 1927 Number 8

Fibroid Tumors; What Determines the Selection of Radium or Operation in the Treatment?*

By JOHN OSBORN POLAK, M. D.
Brooklyn, N. Y.

In this day of surgery there has been so much operating done on fibroids that when the radiologist came along with his palliative treatment, every one turned to the radiologist. The result has been that the public has, as usual, had the wrong end of it, and while there are cases of fibroid tumor which are amenable to radium and x-ray treatment, there are also a very large number of cases in which radium and x-ray will only do harm.

It is on this supposition that I wish to carry you through the growth and development of fibroids and show you how we can determine in which class of case to seek the aid of the radiologist and which class of case the skill of the surgeon.

There is practically little known about the origin of fibroids. It is generally accepted that they have their origin in the fibrous tissue in the walls of the blood vessels, develop from these congenital rests, and we do know there are certain women of predominating endocrine types, known as the pituitary and the sub-thyroid type, who are more prone to develop fibroids than any other class of women.

This first picture will show you the different locations where we find these congenital rests, showing you the sharply defined fibroid within the uterine wall, surrounded, as it is by uterine muscle in the muscle but not of it.

A fibroid, under the stimulus of uterine contraction, and under the stimulus of changed circulation as occurs in pregnancy, or under the continuous stimulus of repeated menstruation not only grows but changes its position. For what happens to any individual growth must depend upon two factors: (1) the relation which the tumor has to muscle tissue, how much muscle tissue there is on either side of it, and (2) on its relation to the blood vessels.

*Stenographic report of discussion before the 85th Anniversary Meeting, State Medical Society of Wisconsin, Madison, September, 1926.

In the next slide I will show you a transverse section of the uterus, which demonstrates the arterial blood supply, and you will notice one important point, and that is the arterial blood supply from the uterine artery on either side comes through the arcuate arteries, and these break up into the intermuscular branches and finally terminate in arterials in the endometrium.

I further wish you to notice that the great mass of circulation is in the outer third of the uterus, while the paucity of the circulation is in relation to the endometrium. This is an important point to remember when dealing with fibroid tumors and selecting the form of treatment for their cure.

The next slide shows you the venous circulation, and again you will notice that in the venous circulation we have a comparable arrangement, that is the mass of the circulation is in the outer third of the uterus, while there is a paucity of the circulation in the endometrium. These two points are important, for the position and the development of the fibroid determines the symptomatology.

The symptoms of fibroids may briefly be classed under three general groups: (1) changes in menstrual history; (2) pressure symptoms produced by tumor pressure on nerves, vessels or contiguous organs; (3) those due to the increased growth of the tumor. All the others are secondary to these three groups.

We will now follow the development of three fibroid tumors situated in different parts of the myometrium and show you how each symptom is produced and why one type is amenable to radium treatment while the other types are not amenable to radium treatment.

You will notice these three fibroid tumors. One is placed distal to the circulation and just under the peritoneal covering of the uterus; one is in close contact with the circulation having an equal

amount of muscle on either side; and one is in rather close contact with the endometrium. All fibroids grow, and as they grow and develop their life history depends on their relation to the circulation and the surrounding muscle. As they grow certain things must happen. The tumor nearest the peritoneal surface, because the mass of muscle is on its proximal side, is pushed out underneath the peritoneum and becomes a sub-peritoneal tumor, but as it is distal to the circulation and carries its capsule with it, the tumor is going to have a very poor blood supply, develop slowly, and is liable to degenerative changes.

On the other hand, an intramural tumor, developing entirely within the wall of the uterus, surrounded on all sides by an almost equal amount of muscle, is not extruded either one way or the other. It has its circulation completely around it. A tumor in such a location is less liable to circulatory degeneration, less liable to change, less liable to rapid growth than tumors in other locations.

The submucous tumor, on the other hand, is in close relation to the endometrium. The great mass of the muscle wall is distal to it. The result is that such a tumor is pushed into the uterine cavity and certain things will happen to it. First of all, we notice that it changes the character and the thickness of the endometrium. In other words, it stretches the endometrium over it and by tissue pressure changes the normal endometrium into an atrophic endometrium. An atrophic endometrium necessarily has a poor circulation. Any tissue which is stretched to such a degree that its circulation is cut off is liable to break down, which is the reason that we have the terminal necrosis and the metrorrhagias in these submucous and polypoid tumors.

You will further notice in the development of these three tumors that the intramural growth carries its capsule and its circulation with it as it changes its position. A sub-peritoneal tumor has a paucity of circulation but the submucous growth is extruded into the cavity of the uterus and produces certain physical signs that are characteristic of all submucous fibroids, i. e., hemorrhage, increased length and tortuosity of the cavity of the uterus and increased area of endometrial response.

The normal histologic structure of the fibroid is made up largely of fibrous tissue with a few muscle bands running through it, white, pearly, whorl-like in character. Its blood supply comes from the capsule and by intralobular twigs and just the moment that the blood supply changes we begin to get degeneration changes in the texture of the tumor.

Some fibroid tumors produce no symptoms and the fibroids that you see which produce no symptoms whatsoever are always small, intramural fibroids, or subperitoneal fibroids that are not large enough to produce pressure symptoms on the contiguous organs.

A woman may go to her physician, he examines her and finds the uterus increased in size, increased in density or sometimes she is told she is pregnant. You reexamine her and find that there is not the elasticity or compressibility of the lower segment of the uterus or the flexibility of the cervix which is characteristic of pregnancy, that she is not pregnant but has a tumor mass in the anterior uterine wall. You watch the woman; no symptoms take place; yet, she is apprehensive and comes back. You find that she has an intramural fibroid which grows slowly, more slowly than almost any other type of fibroid, but as it grows it increases the area of endometrial response, it increases the length of the uterine cavity, it changes the contour or the shape of the cavity, and with that we have increased menstruation and co-menstrual uterine pain.

On the other hand, if the tumor is a submucous growth, almost from its incipiency we get some little change in the menstrual story. Not infrequently these women are sterile. Why? Because the character of the endometrium is changed owing to the relation of the tumor to the endometrium, the pressure upon it changing the character of the glands while the foreign body excites more active contractions. A submucous fibroid is extruded, as all fibroids are extruded in the direction of least resistance. The submucous tumor is extruded into the cavity of the uterus, pushes the endometrium before it and enlarges the cavity of the uterus, increases the amount and duration of menstruation, changes it from a painless period to one with comenstrual cramp-like pain because of the intrauterine content until the tumor is finally extruded as a submucous polyp when metrorrhagia becomes the prominent symptom.

We have at first with each menstural period cramp-like pains simulating labor pains, and then gradually as the cervix becomes dilated the pains disappear, but the menorrhagia is supplanted by

the symptom of metrorrhagia owing to a terminal necrosis in the atrophic endometrium covering the tumor.

This mentrual chart shows you certain characteristic types of bleeding seen in different fibroids. Here is a woman, we will say, of the sub-thyroid or hyper-pituitary type who has menstruated regularly every month, but since she has been married (and that is another thing which always increases the uterine congestion) we find that her menstruation has gradually lengthened from a three-day to a four-day type. Then as she does not become pregnant, sterility has its effect in the development of fibroids, just as fibroids have their effect on sterility. Gradually the menstruation lasts a little longer and a little longer until we have a menorrhagia. Of what is that typical? It is typical of that first picture of fibroids which I showed you, an intramural or submucous fibroid being gradually extruded into the cavity of the uterus with a large area of endometrial response, and as the tumor is extruded further and further into the cavity the longer and longer becomes the hemorrhage.

Fibroids of the pedunculate type which are extruded into the cavity of the uterus may develop carcinoma on the atrophic endometrium.

The characteristic and diagnostic symptoms which show the development and transition of a submucous fibroid into a polyp are as follows: the woman menstruates profusely but regularly and then at one of her periods she menstruates with severe cramp-like pain; this pain recurs at succeeding periods, then at one of her menstruations these pains become more and more severe, almost labor-like pains, and instead of menstruation ceasing she continues with metrorrhagia. This is the story of these fibroid polypi for we have an atrophic endometrium which by terminal necrosis has become broken.

The submucous fibroid complicating pregnancy also gives a typical story. A woman menstruating regularly but rather profusely becomes pregnant. Then there is a period of amenorrhea for nine months. At labor she may have inertia or she may deliver spontaneously. The delivery is followed by a post partum hemorrhage owing to the poor contractility and retractility of the uterus. By the use of pituitrin and various ergot preparations the bleeding is controlled. This is followed during the puerperium by a period of amenorrhea with uterine colic which extrudes the tumor into the cavity of the uterus and which in turn occasions a metrorrhagia.

Let me say one thing, that where we have bleeding during the puerperium after the red lochia has ceased, coming on during the second, third, fourth, or fifth week, there are three causes to always keep in your mind, i. e., that the bleeding is either due to subinvolution, a retroflexion or a submucous fibroid.

To refresh your memories a little about menstruation, I would remind you that the ruptured graafian follicle is the provocative impulse while the endometrium supplies the menstrual response. The endometrium is in the resting stage until the graafian follicle ruptures when we have the premenstrual changes, which are marked by glandular hyperplasia, stroma hypertrophy and coincidently the development of the corpus luteum is going on in the ovary.

If impregnation takes place, this development of the corpus luteum undergoes a different formation from what it does if impregnation fails.

The principal changes which take place in the endometrium during the menstrual cycle may be found in the microscopic appearances of the glands, blood vessels and stroma cells. In the resting period before ovulation takes place the glands are straight, separated by wide areas of stroma, but as the ovum escapes, the vessels engorge, the glands increase in number, become more tortuous and their epithelium proliferate, while the stroma becomes more compact, filled with serum and many red cells until the engorgement is so great that the smaller terminals rupture and bleeding into the cavity occurs by rhexis.

In other words, the sub-epithelial capillary plexus is engorged and the tension becomes so great that it raises the epithelial cells, a leak takes place and menstruation results.

This is an important point for one to remember for in menstruation we have intact epithelial cells, while in the case of the submucous fibroid the tension is often so great that the glands and lining cells are flattened out and we have breaks in the epithelial cover which are not repaired by regeneration.

What actually happens in these cases of submucous myoma when the tumor is extruded into the cavity of the uterus, is that the endometrium is so thinned and atrophied, and the tumor pressure blocks the small veins to such a degree that lakes of blood are formed in the basal mucosa and the

pressure on these lakes becomes so tense that they rupture and we have an open ulcerated surface, a terminal necrosis, which gives rise to a metrorrhagia.

Such a tumor as this is not amenable to x-ray or radium, owing to the paucity of its circulation and the terminal necrosis. This is a class of case which is best treated by vaginal myomectomy through a vaginal hysterotomy wound.

We next come to the consideration of the subperitoneal type. The subperitoneal nodule is located at or near as the fundus underneath the peritoneal layer and the tumor is further extruded with its circulation distal to it, it grows, and because of its weight, is apt to retrovert the uterus, and as it retroverts the uterus it causes a partial twist in the broad ligaments which further interferes with the circulation. The tumor becomes edematous, enlarges and causes further changes in the blood vessels of the tumor. The edema produced in turn changes the character of the overlying peritoneum with resulting adhesions to adjacent viscera. The subperitoneal tumor does not produce bleeding. Why? Because it is not in contact with the endometrium. Its dangers are interference with circulation resulting in edema, which produces a mild type of peritonitis which allows adhesion of the intestine, omentum and other structures, and as a result of these changes we have intestinal disturbances, intestinal obstruction, constipation and pressure necrosis of different kinds.

Subperitoneal tumors are never treated by radium, never treated by x-ray, for it leaves them without a base of supply, it leaves them starved, and a starved tumor is a "bolshevist," and a bolshevist will attack anything. Remember that a subperitoneal tumor and submucous tumor are not to be treated with radium or x-ray.

Tumors causing pressure symptoms may produce disturbances in the adjacent viscera, blood vessels or nerves. Some times the only symptom is frequent urination, unilateral edema of the leg, or unilateral sciatic pain, or difficulty in defecation.

The majority of fibroids develop in the body of the uterus though some of them develop in the cervix. Fibroid rests which develop in the lower uterine segment are usually unsuited for x-ray or radium treatment.

Whenever we have a woman who is suddenly attacked with dysuria and can not urinate, we must immediately think of an incarcerated retroflexed pregnant uterus or an incarcerated fibroid. Both of these conditions can so block the pelvis that the urethra will not allow the passage of urine and the bladder can not be emptied.

This woman was twice operated upon in New York for hemorrhoids by two recognized proctologists. In this case a subperitoneal pelvic tumor blocked the hemorrhoidal veins and naturally produced engorgement of the rectal vessels, with resulting hemorrhoids. Don't forget that where we have hemorrhoids, where we have unilateral varicosities of the leg, where we have unilateral edema of the leg, where we have a chronic mucous discharge from the rectum, we should examine the womans pelvis because not infrequently we will find that it is tumor pressure on the venous circulation in the pelvis which causes these conditions.

Very few cases of fibroid complicating pregnancy demand hysterectomy. We feel that fibroids complicating pregnancy and pregnancy complicating fibroids makes such an interesting discussion that my time will only permit mention of a point or two. A large number of women do not become pregnant as a result of fibroids; in other words, fibroids will produce sterility, and their removal will not infrequently increase the chances of fertility.

On the other hand, fibroids grow as the result of pregnancy, and they grow with great rapidity, and all fibroids as the result of pregnancy and involution undergo definite circulatory changes. What are we going to do with them? I say wait and see. The majority of cases will take care of themselves. We have seen a large number of fibroids located in the lower segment of the uterus pulled out of the pelvis permitting the child to be delivered without the slightest difficulty.

The woman from whom this specimen was removed had a very interesting history. She was sent to us from the clinic with a history of eleven breech presentations, and when the resident physician told me that she had had eleven breech presentations, I said to him, "Where is the fibroid?"

He looked at me in wonder and said, "How did you know she had a fibroid?"

I said, "There must be something in the lower segment of the uterus to prevent the head from coming down because it would be a head if it could have been a head."

This was a case. With a fibroid in the lower segment of the uterus, the head could not adjust itself in the lower segment, but the breech could.

It interfered with delivery, for after dilatation, while it allowed the breech to escape, it locked with the after-coming head.

Tumors in the body and fundus may so interfere with proper contraction and retraction that post partum hemorrhage occurs. Over twenty-five per cent of fibroids complicated with pregnancy have excessive bleeding in the third stage of labor.

This slide illustrates the story of a woman who came to us complaining of dyspareunia and impossibility of consummation of the marriage act. On examination we found the vagina was entirely occluded by a cervical tumor which had grown downward to the vulva beneath the post-vaginal wall; relief only to be given by operation.

Submucous polypi coming from the lower segment of the uterus, and for that matter, every growth of polypoid nature, should be sectioned and subjected to microscopic examination, for sarcoma and carcinoma do occur in these growth. No matter how innocent it looks, have it sectioned, because a certain small percentage of these tumors are malignant.

All of the degenerations in fibroids are the result of circulatory changes. There is either a starvation or excess, just as is found in life.

One of the most common degenerations which we find is what is termed necrobiosis or red degeneration. This occurs most frequently in pregnancy, and it occurs with a symptom complex which is very typical. The woman who is pregnant or known to be pregnant with a tumor or is known to have a tumor which is out of proportion to her period of gestation, is suddenly seized with pain in the lower abdomen and slight vaginal bleeding, she has a rise of temperature, and a leukocytosis. Examination of the tumor shows rapid increase in size and tenderness, so that we have a symptom complex of sudden pain, often a little bloody vaginal discharge, increase in the size of the tumor, tenderness, slight temperature, leukocytosis.

For a number of years I was very much alarmed when faced with this condition as many of the cases simulate an acute abdomen and I operated on a number of them and removed the uterus, until my friend Dr. Ill of Newark, a man of very great experience, said to me, "Polak, you are young, that is the first stage of calcification. Leave them alone." Lately I have sat quiet in the matter and let them cool down, and in three or four days they have quieted down, and when they have done so some times we have operated and found more or less red degeneration and in many other instances we have done nothing and the patient has continued with her pregnancy uninterrupted for nature seems competent to manage most of them.

The next stage following red degeneration is the cystic, and you will notice how these fibrous septa limit the typical cyst cavity within the tumor mass.

With such a condition as this radium and x-ray will give us a further cystic degeneration. *Any soft tumor that rapidly enlarges is a contraindication to radium and x-ray.*

One of the points I wish to leave with you is that no case should be radiated, no case should be x-rayed in the treatment of fibroid tumors that has not been examined under an anesthetic, and furthermore that has not been curetted in order to exclude, as I will show you in a moment, the possibility of carcinomatous implantation.

Cancer may develop in the capsule of any fibroid or occur in the endometrium of a fibroid uterus, independent of the myoma, therefore, never think of using x-ray or radium treatment until you have had a microscopic examination of material removed from the cavity of the uterus. This point is illustrated by the next picture. Here is a fibroid tumor in the uterine wall, and implanted on the endometrium lining the uterus is one of the most typical areas of adenocarcinoma of the body of the uterus which we have ever seen. We readily understand why this is apt to happen, the tumor is extruded into the cavity of the uterus and covered with an atrophic endometrium, an endrometrium without resistance, and consequently in the effort of cell proliferation we have an anomalous cell development. Don't forget that cancer is always a lawless, irregular and untimely proliferation of cells.

Pelvic inflammatory disease complicates fibroids in something like forty to fifty per cent of all cases. My friend Jeff Miller of New Orleans says that it occurs in 100%, but he is dealing with negroes. Up north we haven't quite so many. Pelvic inflammation is a contraindication to radium treatment. Nothing can induce such a severe reaction in a pelvic inflammatory condition as radium.

Radium is of great value as a palliative measure for the control of excessive menstrual bleeding in submucous and intramural growths.

In closing, I would say to you that we have three methods of treating fibroids, i. e., hyste-

rectomy, myomectomy, x-ray and radium; that in young women with submucous, subperitoneal growths and some few interstitial growths properly located, myomectomy is the procedure of choice; that in all rapidly growing tumors where there has been a rapid change in the character of the growth, the tumor rapidly becoming larger or softer, hysterectomy is indicated. The fibroid which is wholly within the confines of the uterine wall, where there is no history of previous pelvic inflammation, where bleeding is the prominent symptom and the cervix is not dilated, radium should be used. But don't forget this one thing, that where we find a woman whose physical picture shows an anemia out of proportion to the amount of blood lost, with some evidence of cachexia, that woman has some degeneration in her fibroid and it is not suitable for radium treatment.

The Status of Roentgen Therapy*

By HARRY R. FOERSTER, M. D.
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The introduction of bills 151A and 102S before the Wisconsin legislature in March, 1927, with reference to the licensure of physicians and technicians employing or wishing to employ the x-rays, called for a definition of the scope and limitations of roentgenology. A special committee of the State Medical Society gathered and presented sufficient information and opinions on the subject matter of these bills to prevent their passage on the just plea that they were not in the public interest. The report of this committee emphasized what many physicians and some laymen know, that technical ability to manipulate an apparatus does not constitute ability and judgment in its use for the diagnosis and treatment of disease.

It is necessary, however, to go a step farther and to point out that license to practice medicine, while it empowers the licensee to employ any or all recognized methods of medical diagnosis and therapy, does not qualify him as competent to employ various refined and complicated procedures. The question, "should roentgenologists be licensed as such and the use of the x-rays restricted to them?", is therefore still open to debate and involves the larger question as to whether all specialists should be licensed and if so what qualifications should be demanded of them.

The fact that there are more malpractice suits against physicians in this state because of injuries and alleged injuries resulting from the use of x-rays, than for any other reason, indicates that there is a lack of understanding and appreciation of the intricacies of roentgenology on the part of a good portion of the 600 owners of x-ray apparatus in Wisconsin. If the use of x-ray apparatus were restricted to roentgenologists, so designated according to our present standards of "specialism," there would still be much malpractice and on the other hand the legitimate use of x-rays would be denied to the competent practitioner.

Roentgenology is an exact medical science, requiring for its successful practice not only an accurate knowledge of apparatus and its management, dosage and its interpretation, biologic principles and normal and pathological anatomy, but also general knowledge of the practice of medicine and sound judgment and experience in that art. License to practice medicine includes the privilege of performing surgery yet every licensee does not operate, for obvious reasons, and the successful surgeon would not be a better surgeon if he were specially privileged by special licensure and designated as a surgeon by a giltedged certificate. Likewise to confine the practice of roentgenology to a certified or licensed group that has met some arbitrary standards of training would not improve those roentgenologists, would place a special mark of apparent competence and skill on some incompetent individuals, and would bar the x-rays to many others capable of performing creditable roentgenology.

A prominent physician or surgeon will occasionally request a roentgenologist in another city to "prescribe x-ray dosage" for a patient the latter has not even seen, such treatment to be given by a lay technician employed by the hospital with which the doctor is identified; or he will send a patient for consultation with the remark that "if x-ray treatment is needed we can give it at our hospital for we have just installed a modern high voltage machine." This state of affairs indicates a lack of understanding and appreciation of roentgenology. The doctor knows that a corps of well trained nurses in a splendidly equipped oper-

*This timely article was written by the author at the request of the Editorial Board of this Journal.

ating room of a modern hospital cannot perform major surgery on the prescription of an internist, but he forgets that the x-ray machine is inanimate and that the brain of the technician does not have in reserve the necessary knowledge to co-ordinate the product of the apparatus with the needs of the case. Even within the ranks of the roentgenologists there is need of enlightenment. Difficulties frequently arise because the roentgenologist does not understand the nature of the disease under treatment and sometimes does not even diagnose the condition correctly. He juggles his mystical volts and milliamperes for an arbitrary dosage and number of treatments, frequently based on supposed normal tissue tolerance rather than on indications for the special condition of disease in that particular patient, and more often than not he fails to take into consideration other therapeutic needs. Reontgenography and roentgen therapy are as different from one another as pathology and surgery. The roentgen therapist and the surgeon must be clinicians, with the clinician's training and point of view, requirements not demanded of the roentgenographer or the pathologist. The roentgenologist who proposes to treat skin diseases intelligently and safely should have a special training and knowledge of dermatology sufficient to qualify him as a dermatologist; if he wishes to treat metabolic disorders, such as toxic goitre, he should possess the judgment of an internist or seek the co-operation of one; and if he wishes to treat deep-seated malignancies he must be conversant with physiology and normal and pathological anatomy. Few roentgenologists can meet these qualifications. On the other hand the dermatologist, internist, and other specialist who wishes to employ the x-rays in treatment must thoroughly master the fundamentals of roentgenology and be drilled in their application and should qualify as a roentgen-therapist before embarking on the hazardous seas of roentgenology.

For these and other reasons, the time is not ripe for the licensure of physicians as roentgenologists. The physician is known to his colleagues and patients not for the title he assumes but for the work he performs. The safety of the public lies not in special license but in the sound judgment of its physicians not to employ methods of diagnosis or treatment with which they are not sufficiently skilled either through training or experience.

Limitations of Roentgen Diagnosis*

By FRED J. HODGES, M. D.
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This topic was selected for the evening's discussion with a definite purpose in mind; not with the intention of discrediting roentgenology but rather with the hope of creating for this specialty a more wholesome appreciation by an attempt to evaluate its scope and practical worth. There is no surer way to discredit a therapeutic agent or a diagnostic procedure than to make exhorbitant claims for its efficacy. The reaction of public and profession alike to failures following over-enthusiastic advance publicity is one of keen disappointment and more or less complete loss of confidence though the agency may possess many worth while features. Enthusiasm in a newly presented aspect of medical diagnosis or treatment is to be expected of its originators but unless this enthusiasm is tempered with caution and modesty, overzealous proponents may actually hinder its widespread application to clinical medicine. In short criticism, like charity, should begin at home and it is for this reason that the roentgenologist must himself point out the limitations and pitfalls of roentgen diagnosis.

The medical profession honors and reveres the achievements of many great men because of the far-reaching benefits to humanity which have followed their work. In the case of nearly all of these historical figures the original contribution consisted of a single new idea presented after careful study, verification and interpretation. The years which have followed these new thoughts have given rise to a maize of developments so complex that the originators could scarcely be expected to recognize their contributions in modern dress. In the case of Wm. K. Roentgen the original gift to medicine was a method for determining variations in density within solid objects opaque to visible light. Today, thirty-one years after his discovery and three and one-half years after his death, we are using his gift to diagnose bone pathology of all types; abnormal fluid accumulations in various body cavities; the presence of foreign

*Read before Annual Meeting of Dane County Medical Society, December 28, 1926.

bodies in alimentary canal, respiratory system and in body tissues and various pathological changes in the urinary, respiratory, alimentary, circulatory and central nervous systems. All this we are doing in addition to employing his discovery as a therapeutic agent and in addition to numerous non-medical procedures carried out in the field of commerce. We have indeed gone far and yet we are still merely "determining variations in density within solid objects opaque to visible light," we have merely embraced this sixth sense as a valuable asset in tracking down evidences of disease and with an ingenuity, perhaps somewhat more spectacular in this field than in others; we have discovered various ways and means of amplifying and recording otherwise slight differences in density to such a degree that we now localize minute foreign bodies in an eye and feel qualified to pass judgment as to the functional status of a gall-bladder.

There is nothing occult about the practice of roentgenography. In fact good results are based upon principles which are so rigidly fixed as to be annoying for by disregarding rules governing voltage, current, distance, time, type of film and screen, type of tube, use of Potter-Bucky diaphragm and technic of developing, films can be utterly ruined as far as diagnostic value is concerned. With adequate apparatus and painstaking technic good films can be made by anyone who will thoroughly master the basic principles just outlined; assuming of course a certain degree of ingenuity in the matter of taking films in difficult positions. However, to thoroughly master the technic is a task requiring application and study with sufficient experience to drive home the necessity for precision.

THE TECHNICIAN

The interpretation of finished films is quite another story. A thorough and constantly refreshed knowledge of human anatomy is essential if one is to recognize differences in density as due to particular structural entities. A well trained anatomist sees infinitely more in the average normal roentgenogram than the average practitioner of medicine. But we use the roentgen ray to study structures known or thought to be diseased so that without a rather comprehensive knowledge of pathology an observer is scarcely qualified to pass judgment from a roentgenogram, even though the patient himself could diagnose a compound fracture of the middle third of the femur as well from the film as from the bone spicule protruding from his skin. In studying the gastro-intestinal tract by roentgen methods surely previous study of the fundamentals of alimentary physiology are a prerequisite if valuable observations are to be made.

It is obvious, of course, that the point being argued is the necessity for a medical education before any observer can qualify as a roentgenologist, or radiologist, a term which implies an individual trained and competent to apply the roentgen ray to useful medical purposes. The radiological technician has a well defined place in this field similar to the clinical laboratory technician, but physicians in general should demand of such technicians the same degree of training and should impose the most careful restrictions on their field of activity. The qualified radiological technician may be a valuable assistant in this specialty but one, who, lacking the hard-won training of a course in medicine can never supplant the roentgenologist if we are to consider the patient's interest.

These matters have been mentioned to point out one great fundamental limitation or shortcoming of roentgen diagnosis. It took the profession generations to build up a code for nurses' qualifications and the nursing profession itself has added years of effort to further define its own standards. Roentgenology is so young in comparison to medicine as a whole that it is still at work putting its house in order and rest of the profession have been slow to aid in the work. The result of this apathy has been that surgeons who would immediately resent corrections or suggested alterations of their diagnoses by their surgical nurses or floor superintendents are in the habit of openly consulting even unlicensed non-medical radiological workers in making diagnoses, a state of affairs surely not in keeping with any accepted medical standard.

Another shortcoming of roentgen diagnosis is noted by the practitioner who sends patients to roentgenology for gastro-intestinal diagnosis. The report comes back "duodenal ulcer" but after convincing the patient that operation is essential no ulcer is found! For this there are three explanations. Perhaps the one giving the diagnosis is not well trained and has made a gross error in mistaking spasm for an organic lesion, perhaps despite every possible effort to relax the stomach and duodenum adhesions between gall-bladder and duodenum have caused the deformity upon which

diagnosis must be made and possibly the ulcer is actually there but insufficiently indurated to be felt without opening the gut. There is no one infallible criterion by which one can rule ulcer or no ulcer, and medical judgment plays an important part.

Another man will complain that he can never rely upon the roentgen diagnosis of the activity or quiesence of a tuberculous pulmonary lesion. That is altogether fitting and proper for tubercle bacilli do not cast shadows sufficiently large or distinct to be seen with the naked eye. Though the physician can be furnished with accurate and reliable information concerning the air content, extent of fibrosis or calcification of the lung or the existence of cavities or fluid accumulations (which should greatly amplify his observations made with older methods), it is impossible for the roentgenologist to foretell the course of the disease from one still view of a chest.

Osteomyelitis can be well established before the most clever roentgenologist can demonstrate bone pathology for not until bone density has been altered will his shadow chart show a change from the normal. Repeated films will however catch the process at about the tenth day which is frequently sooner than the surgeon could be sure.

Roentgenograms of sinuses have in the past at least, been particularly disappointing to rhinologists. Great strides in this field have recently been made as the result of careful studies on cadavers which have shown that accurate position of subject and tube are necessary to the making of diagnostic sinus films. Even then early infections, regardless of virulence, are difficult if not entirely impossible to demonstrate because again unless an abnormal relationship of very complex dense and transparent areas exists there is nothing upon which to base a diagnosis.

The roentgen ray easily detects large, encapsulated periapical dental infections or old processes which have resulted in protective bone proliferation but until some bony change is brought about infected roots may appear perfectly innocent.

SUMMARY

The entire field might be so covered but in every case the explanations would be similar and every roentgenological procedure would fall down at some point. After all it is but logical that limitations should exist for no branch of medicine or surgery is exempt from failures and yet each has its field of usefulness. It is not the purpose of this discussion to imply previous censure or criticism, much less to resent what may in the future be deserved but rather to help the physician to make the most of roentgen diagnosis when he has occasion to rely upon it. It is said that the time will come when every physician will employ the roentgen ray himself as he would a microscope, yet even today few of us rely upon our own judgment in microscopic examinations, leaving that phase of diagnosis to specially trained workers. Granting that for a time at least roentgenologists will exist as such, the referring physician will be assured of the greatest possible assistance in this field if he will:

1. Request roentgen consultations rather than "x-ray pictures."
2. Consider resulting reports as additional data rather than final unequivocal diagnoses.
3. Remember that in his own field a positive "yes" or "no" answer cannot always be given.
4. Be as particular in the selection of his roentgenological consultant as he would be in the selection of a consulting surgeon, and
5. Remember that all anyone can do in roentgen diagnosis is to interpret "variations in density within solid objects opaque to visible light."

Human Anomalies, Practical Roentgenographic Studies, Study I; Abnormal Crania-Hydrocephalic, Achondroplastic, Oxycephalic and Acromegalic*

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The extent to which the anatomy of the head, as studied from the standpoint of its size, shape, irregularities and physiognomy, may suggest points of practical value to the general practitioner has not been sufficiently utilized in my opinion by medical students. Direct inspection of the size, shape and irregularities of the skull and with the aid of a roentgenogram, may be a source of diagnosis, of many conditions, which seldom fails the practitioner who is himself well versed in the interpretation of what he observes. The patients possessing the abnormal conditions of the crania, herein described, were observed by me in the Marquette University Free Dispensary and Hospital.

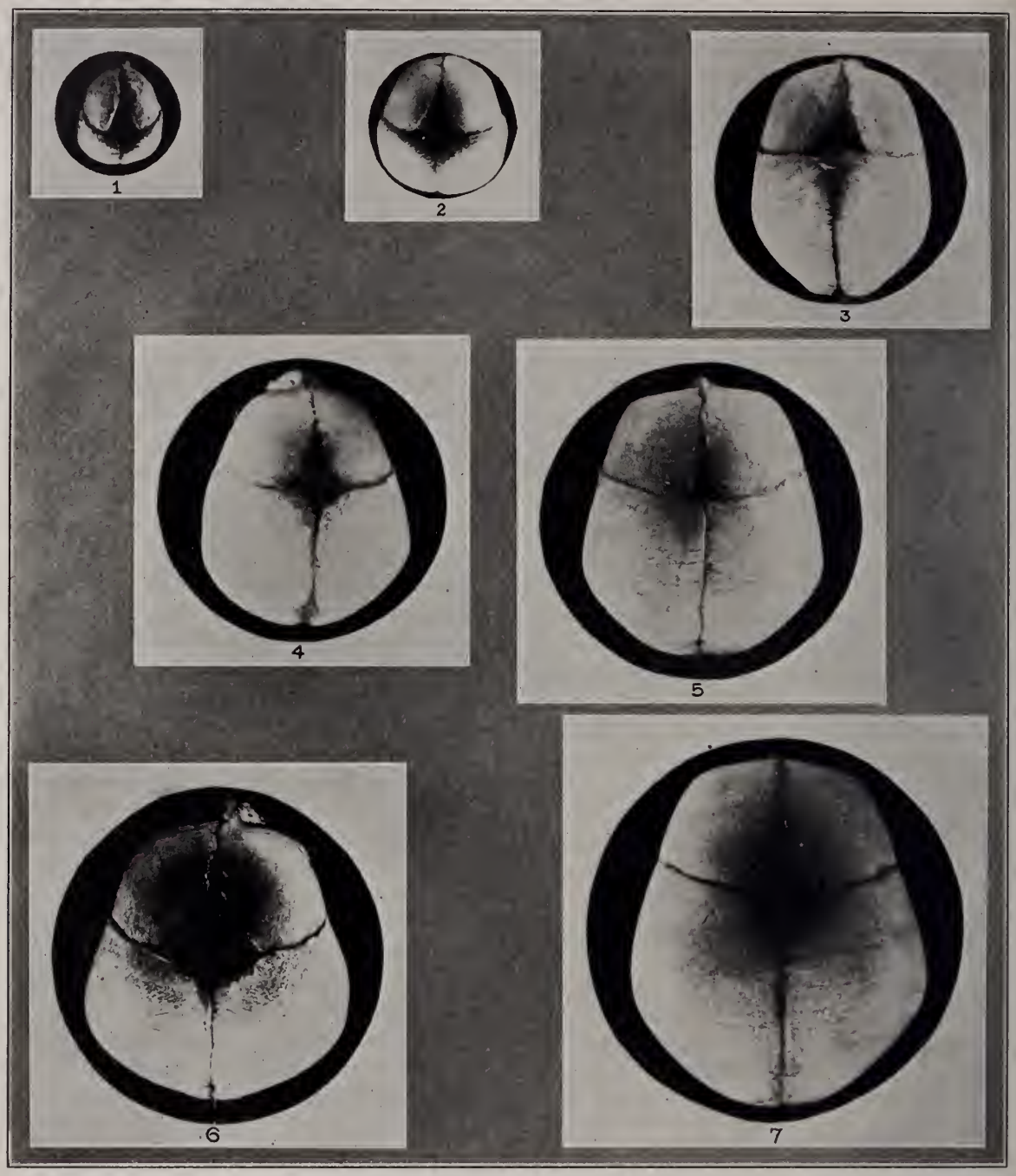

PLATE 1

Fig. 1. Photograph of third month pre-natal cranium (cephalic aspect).
Fig. 2. Photograph of fourth month pre-natal cranium (cephalic aspect).
Fig. 3. Photograph of fifth month pre-natal cranium (cephalic aspect).
Fig. 4. Photograph of sixth month pre-natal cranium. (cephalic aspect).
Fig. 5. Photograph of seventh month pre-natal cranium (cephalic aspect).
Fig. 6. Photograph of eighth month pre-natal cranium (cephalic aspect).
Fig. 7. Photograph of ninth month pre-natal cranium (cephalic aspect).

The diamond shaped anterior fontanelle is proportionately larger in the third month pre-natal cranium than in the one at the ninth month. The frontal region is proportionately larger in the third month pre-natal cranium than in the ninth month cranium. As development progresses during early post-natal life the skull of the infant is proportionately larger in the occipito-parietal region than in the frontal zone. The face is extremely small in comparison to the skull. The coronal crosses the sagittal suture from left to right, forming a crucial figure in this view with the triangular posterior fontanelle appearing at the dorsal border of the sagittal suture in Fig. 7.

VARIATIONS IN FORM

The head varies in form due to age, sex, racial characteristics, chemical and mechanical causes.

The skull of the infant is large in the occiput-parietal region, whereas, the frontal region and face are imperfectly developed. (See Plate I, II and III). The face is only one-eighth of the entire weight of the skull. The sutures are separated or imperfectly closed and the fontanelles are present. As childhood comes on, the frontal and parietal regions develop more rapidly than the occipital and give the head a more symmetrical appearance. The weight of the face may reach one-third that of the skull.

The skull of the female is characterized by the following: the bones are smoother, lighter and smaller; the face is smaller in proportion to that of the skull; the frontal sinuses are smaller than those of the male; the parietal region is proportionally larger than the frontal and the occipital region; the jaws are much narrower than in the male. (See Plate IV.)

The smallest skulls are found in the Hindu and the ancient Peruvian races and the largest in the Scandinavian races. The skull of the Ethiopian race has the following characteristics:

Prominent temporal regions; wide zygomatic arches; wide anterior nares; long and strong jaws; long incisor teeth, whose direction are oblique rather than right angle as found in the higher races; prominent points for muscular attachments.

The deviation in forms produced by chemical and mechanical causes are as follows: non closure of the sutures as in hydrocephalus; imperfect ossification as in rickets; excessive development as in gigantism and acromegaly; irregularities in shape due to achondroplasia and synostosis dependent upon a premature closure of the sutures as in synostosis; acquired distortion from compression as in the flat-head Indian tribe in the western part of the United States and new growths.

The head consists of the cranium and face; the cranium contains the brain and the organ of hearing; the face includes the organs of sight, smell and taste. The more the organs of sight, smell and taste are developed the larger is the face and the greater its relative proportion to that of the cranium. On the other hand the larger the brain, the greater must be the capacity of the skull and the greater its proportion to the face.

The facial index of Camper is found as follows: draw a line upward from the side of the chin to the most prominent part of the forehead, it will form an angle with the horizontal line drawn dorsad from the upper margin of the anterior nares in the living through the external auditory meatus. The size of the angle so formed will indicate the degree of development of the cranium and the brain as compared with that of the face and the organs of sense. In the crocodile this angle is not more than five degrees. In the horse twenty-three degrees, in the dog twenty to thirty-five degrees, in the orangoutang sixty degrees and in the European adult eighty-five to ninety-five degrees. Pathologically this angle may be as great as one hundred and ten or one hundred and twenty degrees in cases of hydrocephalus with marked over projection of the frontal region compared to the chin.

Among the gross abnormalities of the skull as a whole, occasionally seen in dispensary practice, are oxycephaly, achondroplasia hydrocephalus and acromegaly. In these conditions there is marked alteration in the size and contour of the skull which may be evident either before or after birth. The differential diagnosis may be frequently made by inspection. In each condition the radiographic findings are characteristic and conclusive.

1. THE HYDROCEPHALIC CRANIUM
(Plate 4, Fig. 25.)

Hydrocephalus in infancy may be defined as an affection of the head, which results in an alteration in the size and shape of the skull either before or after birth due to an accumulation of cerebrospinal fluid in the brain and its membranes. According to Dorland and Hubeny ('26) this condition occurs about once in 1,500 cases. These changes of the head are well depicted in the accompanying radiograph. (Fig. 25), Marquette University Hospital No. 9856.

*These studies of anomalies found in patients at the Marquette University Hospital will include;—Study I. The Cranium. II. Spine. III. Thorax. IV. Abdomen and Pelvis. V. Upper Extremity. VI. Lower Extremity. They have been presented in five papers; (1) read before the Wisconsin State Roentgenological Society and Outagamie County Medical Society, Appleton, Wisconsin, November, 1925; (2) read before the Radiological Society of North America, Milwaukee, Wisconsin, November, 1926; (3) read before the Chicago Roentgen Ray Society at Chicago, February 14, 1927; (4) read before the Englewood branch, Chicago Medical Society of Chicago, May 3, 1927; (5) read before the Chippewa County Medical Society, at Chippewa Falls, Wisconsin, June 13, 1927. I wish to thank Mr. Leo Massopust of the Anatomical Department of Marquette University for valuable aid in preparing the beautiful illustrations for these studies.

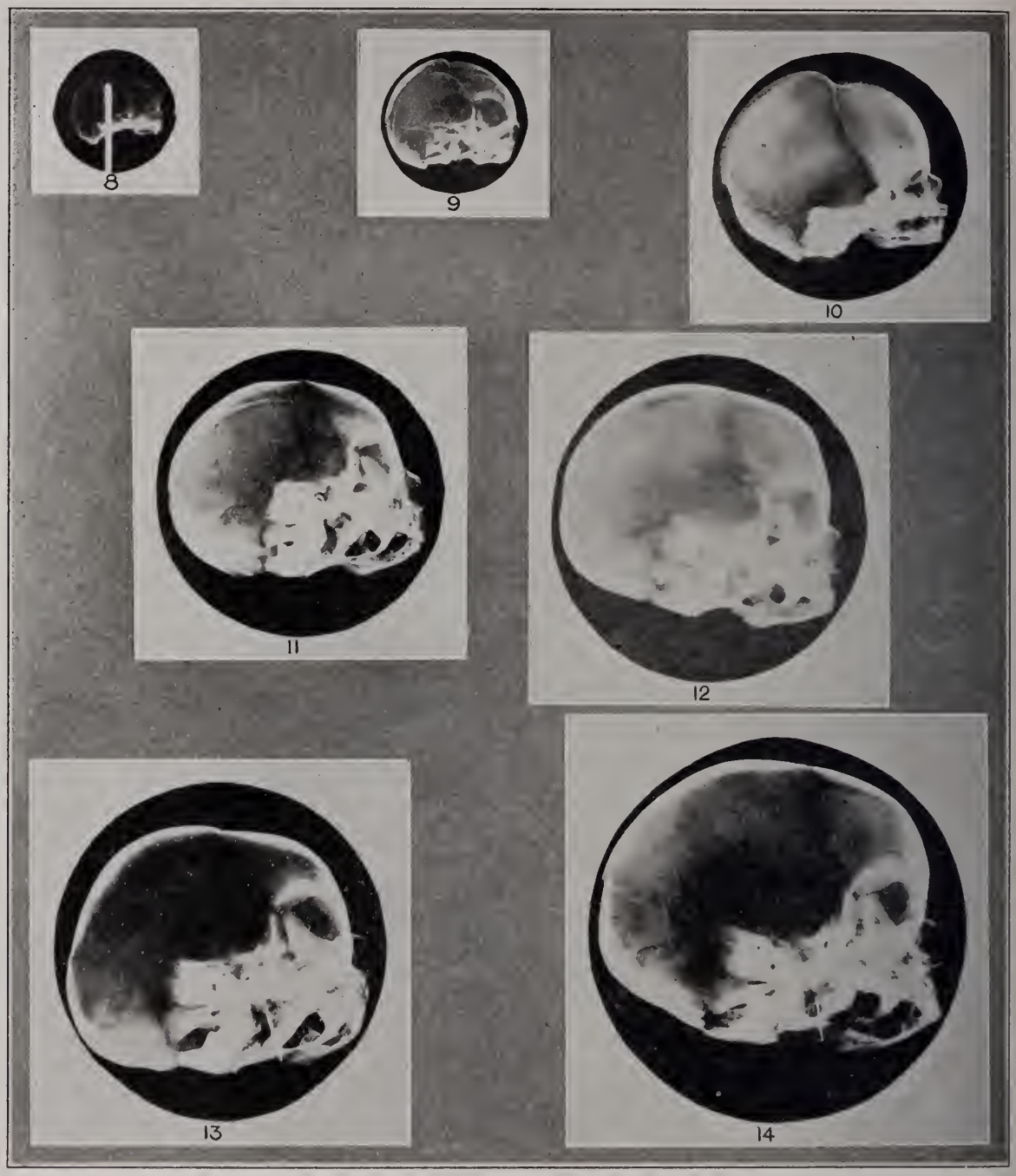

PLATE 2

Fig. 8. Roentgenogram of third month pre-natal cranium.

Fig. 9. Roentgenogram of fourth month pre-natal cranium.

Fig. 10. Roentgenogram of fifth month pre-natal cranium.

Fig. 11. Roentgenogram of sixth month pre-natal cranium.

Fig. 12. Roentgenogram of seventh month pre-natal cranium.

Fig. 13. Roentgenogram of eighth month pre-natal cranium.

Fig. 14. Roentgenogram of ninth month pre-natal cranium.

The decrease in radiability of the cranium from the third to the ninth month is directly proportional to the advance of the process of ossification. The contrast between the bone formed in cartilage and that formed in membrane is immediately evident by the increase in density of the former over that of the latter. The cartilage bone at the base of the skull especially in the middle fossa around the sella turcica is more dense than that over the sides and vault of the skull. This density is evident by the more light appearance of the bone at the base of the skull in contrast to the more dark appearance of the vault and sides of the cranium.

The countenance of chronic hydrocephalus is perhaps, the most typical of any of the conditions to which the attention of the general practitioner is directed. In it the frontal bone is tilted forward so that the forehead, instead of slanting a little backward, rises perpendicularly or even juts out at its upper part and overhangs the brow. The parietal bones bulge above toward the sides, the occiput is pushed backward and the head becomes long, broad and deep, but flattened on the top. This, at least, is the most ordinary result. In some instances however, the skull rises up in a conical form like a sugar-loaf. Not infrequently the whole head is irregularly deformed, the two sides being asymmetrical. Some of these rarer varieties of form are fixed and connate, others are, owing probably to the kind of external pressure to which the head has been subjected. While the skull may be rapidly enlarging, the bones of the face grow no faster than usual, perhaps, not even so fast, and the disproportion that results gives an odd and peculiar physiognomy to the unhappy subjects of this calamity. They have not the usual round or oval face of childhood. The forehead is broad, and the outline of the feature tapers toward the chin. The visage is triangular. The great disproportion in size between the head and the face is diagnostic of the disease and would serve to distinguish the skull of the hydrocephalic child from that of gigantism. In acute cerebral diseases, the countenance is either wild or excited, lethargic and expressionless.

The condition of hydrocephalus in the foetus "in utero" has been radiographically diagnosed by R. A. Bartholomew ('23) and W. F. Schallenberger ('26). In one case there was a vertex and in the other a breech presentation. In Bartholomew's case the x-ray examination revealed the head, which was presenting as a right occipito-anterior, much out of proportion to the pelvis and a diagnosis of hydrocephalus was made. A spina bifida occupied the lower eight vertebrae. Bartholomew, believes that the foetal bradycardia is a characteristic symptom of intrauterine hydrocephalus. He believes that the increased intracranial pressure results in an inhibition of the cardiac rate due to vagus stimulation.

Shallenberger's case recorded by Dorland and Hubeny ('26) was a hydrocephalic foetus in a breech presentation. It was diagnosed prior to birth by means of the x-ray. This infant also possessed a spina bifida.

Dandy ('19) has produced internal hydrocephalus experimentally on dogs. He has demonstrated that cerebrospinal fluid is formed by the choroid plexus and that the accumulation of fluid in the cerebral ventricles is due to an obstruction in the aqueduct of Sylvius and in the foramen of Monroe. Dandy removed the choroid plexus of the one ventricle at the same time obliterating the foramen of Monroe. There is no dilatation of the corresponding ventricle but there is ventricular collapse. The ependyma does not secrete cerebrospinal fluid. By the removal of choroid plexus of both lateral ventricles and by obstructing the aqueduct of Sylvius, hydrocephalus results in the third and in both lateral ventricles at a reduced rate. This accumulation of fluid is due to the choroid plexus of the third ventricle and is unable to escape into the subarachnoid space. The formation of cerebrospinal fluid therefore, is from the choroid plexus of the cerebral ventricles and is reabsorbed almost entirely in the subarachnoid space overlying the cerebral cortex and spinal cord. The lateral foramina of Luschka and median foramen of Magendi are the only means of communication between the subarachnoid space and the ventricular system. Obliteration of these foramina either experimentally or pathologically results in hydrocephalus. By ligating the great vein of Galen the venous drainage of the interior of the cerebral hemispheres, hydrocephalus results due to an overproduction of cerebrospinal fluid. In the obstructive and communicating types of hydrocephalus the intra-ventricular accumulation of fluid is due to the diminished absorption of cerebrospinal fluid.

Dandy ('18) first performed ventriculography or cerebral pneumography by injecting air into the lateral ventricles. The diagnosis of hydrocephalus is absolute by this method. The degree of hydrocephalus and the amount of brain destruction are at once evident from the ventriculogram. With exact visualization of the ventricles the findings are pathognomic. Early diagnosis of internal hydrocephalus may thus be made. The plausibility of ventrilography was suggested by the fact that in a traumatic pneumocranium there were no unpleasant symptoms when air was thus accidentally introduced into the ventricles and furthermore, by the fact that when air displaces the cerebrospinal fluid a distinct shadow-cast of the ventricles is possible.

With the introduction of air into the lateral

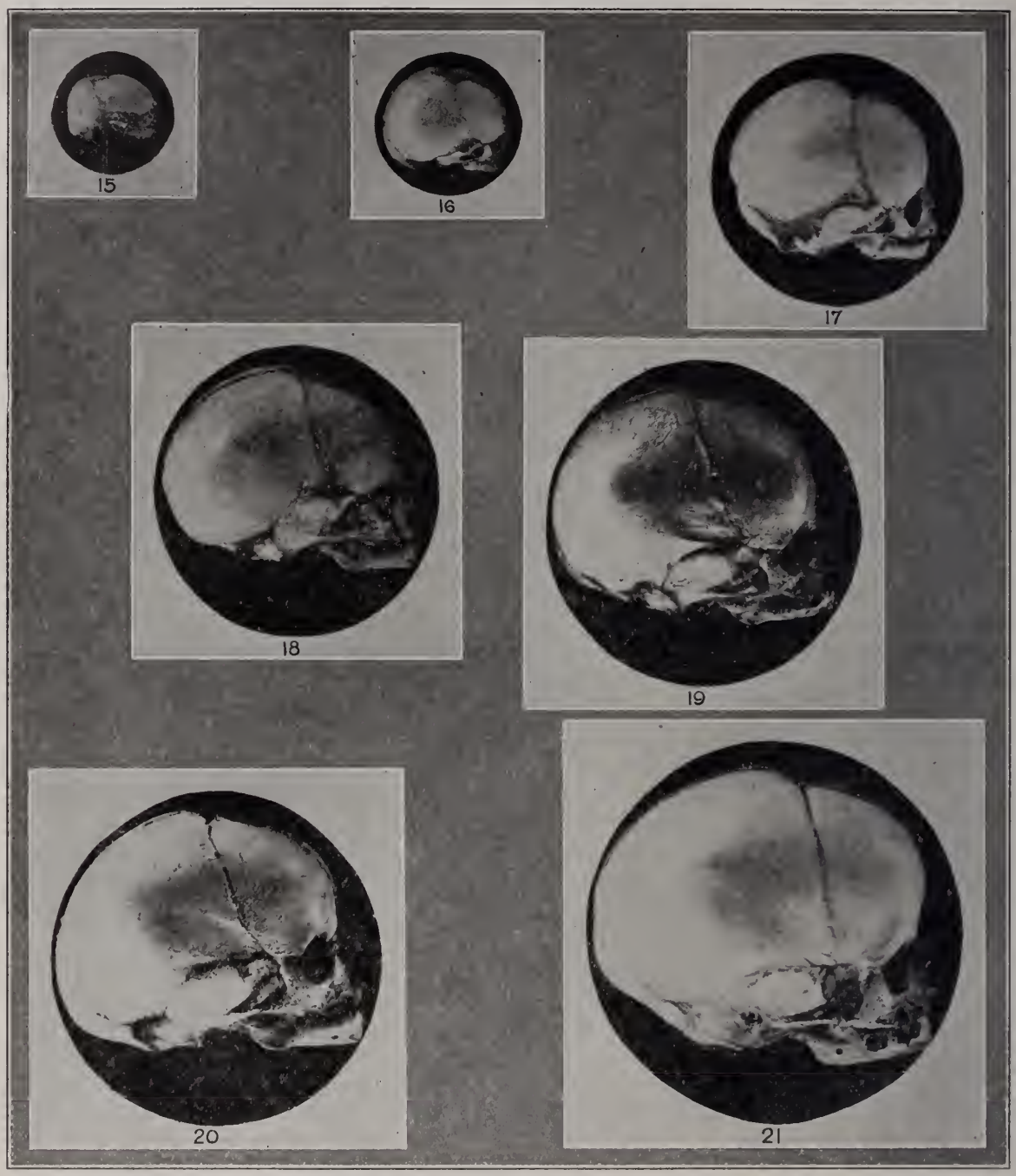

PLATE 3

Fig. 15. Photograph of third month pre-natal cranium.
Fig. 16. Photograph of fourth month pre-natal cranium.
Fig. 17. Photograph of fifth month pre-natal cranium.
Fig. 18. Photograph of sixth month pre-natal cranium.
Fig. 19. Photograph of seventh month pre-natal cranium.
Fig. 20. Photograph of eighth month pre-natal cranium.
Fig. 21. Photograph of ninth month pre-natal cranium.

From this aspect it is seen that the frontal region is proportionately larger in the third month pre-natal cranium than in the ninth month cranium. The relative preponderance of the occipito-parietal region in the ninth month cranium is evident. The face is extremely small in comparison to the cranium, being usually only one-eighth of the entire weight of the skull. The sutures and the two lateral fontanelles are open. In the post-natal skull of childhood the face increases in its relative size, reaching one-third the weight of the skull; and the frontal and parietal regions also develop rapidly, giving the head a more symmetrical appearance.

ventricles there may be occasionally a rise in temperature, nausea, vomiting and headache. These symptoms are quickly relieved when the air is released by a ventricular puncture. The air shadow gradually diminishes and finally disappears. This may take as long as two weeks.

II. THE ACHONDROPLASTIC CRANIUM

(Plate 5, Fig. 27)

The conclusion drawn by Arthur Keith ('13) from his studies of achondroplasia is that this condition is essentially a disease of ossification. The site of this disease is limited to those lines, intermediate cartilage, where bone is replacing cartilage. In normal ossification the cartilage cells adjoining the advancing line of ossification undergo certain definite changes preparatory to their place being taken by bone forming cells; in achondroplasia these pre-ossification changes in the cartilage cells do not take place. Keith believes that the stimulus which brings about the pre-ossification changes in the cartilage cells is a hormone, such as we may expect to arise either in the pituitary, thyroid, suprarenal, or genital glands or by an interaction of secretions of all of these.

Murk Jansen ('12) believes that the cranial features of achondroplasia are due to a compression of the embryo by a congenitally small amnion. Jansen's interpretation therefore, is a mechanical one of this condition entirely at variance with the chemical hormone theory advanced by Keith. Keith believes that an explanation of this strange disorder of the growth of bones will be found in a fuller knowledge of the action of internal secretions; in other words, achondroplasia is a disturbance of those factors which regulate normal growth.

There is an arrested growth of the bones entering into the formation of the posterior cranial fossa in the achondroplastic cranium. The main abnormality is in the occipital bone. There is an arrested or passive condition of the cartilage cells bordering the line of bone growth. The following are the main points of difference between a normal and an achondroplastic occipital bone: in the achondroplastic bone the membranous part of the supra-occipital forms the major part of the squama occipitalis and the foramen magnum is reduced one half its normal size and the suture between the basi-occipital and basi-sphenoid is abnormally closed; the sutures between the ex-occipital and the other components of the occipital bone are practically closed. In the occipital bone there is first a failure of the cartilaginous part to grow and second a compensatory growth in the supra-occipital membraneous part. The cartilaginous part of the occipital bone of the achondroplastic is small in amount and reaches maturity precociously.

The attachment of the tentorium lies opposite the lambda instead of the inion owing to the cartilaginous part of the occipital bone failing to provide sufficient room for the normal cerebellum. The cartilaginous part of the supra-occipital forms an irregular mass behind the foramen magnum. The basi-occipital, basi-sphenoid, and presphenoid form an irregular mass ventral to the foramen magnum. The direction of the process of ossification is toward the dorsum sellae and toward the mes-ethmoid. The other sutural lines have disappeared. The parts forming the posterior cranial fossa therefore, are arrested and stunted in growth. According to Keith ('12), "there is no arrest in the growth of cartilage; there is only an arrest of the production of bone in cartilage."

The chief x-ray features of the achondroplastic cranium are the following:—1. The contraction of the foramen magnum; 2. shortening of the basi-occipital and basi-sphenoid; 3. contraction of the naso-pharyngeal space; 4. arrest of pre-sphenoid ossification and hence, the distance of the pituitary fossae from the foramen caecum or fronto-ethmoidal junction is markedly reduced with the result that the region of the nasion is retracted inwards; 5. nasal retraction, however, is primarily due to a bulging of the frontal region (frontocephaly) caused by the brain seeking compensatory space due to the arrest of growth in the posterior fossae; the posterior fossae of the skull retains infantile characteristics; 6. the pituitary fossae is distinctly very small; 7. the sagittal and lambdoidal sutures are prematurely fused; 8. the coronal suture is open; 9. due to the non-expansion of the posterior cranial fossae the cerebellum has lifted the lateral sinuses up to or above the lambdoidal suture; 10. the frontal bone is thick and bulges forward; 11. there is narrowness of the base of the skull from side to side; 12. the calvarium of the skull viewed from the vertex is pear-shaped with the largest diameter dorsal to the bi-parietal diameter; 13. the process of ossification at the base of the skull, due to the lack of production of cartilage cells, soon pervades the whole thickness of the sutures and hence the result is

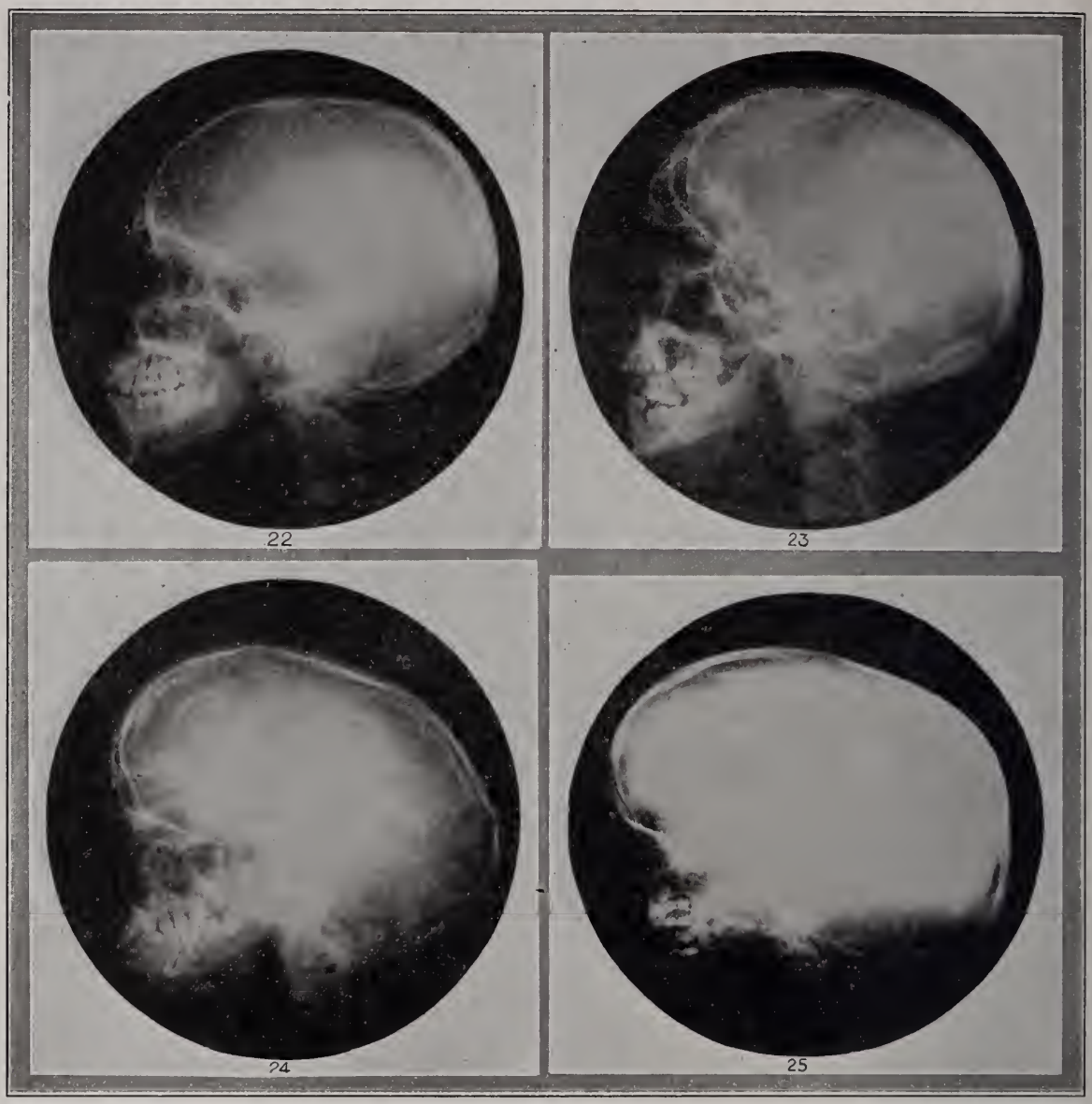

PLATE 4

Fig. 22. Roentgenogram of lateral aspect of normal symmetrical skull. (Brachiocephalic type, adult female, 35 years of age).

Fig. 23. Roentgenogram of lateral aspect of a normal cranium with more marked development of the frontal sinuses. (Adult male, 40 years.)

Fig. 24. Roentgenogram of lateral aspect of a dolichocephalic cranium. (Adult male, 38 years.) This cranium is proportionately longer from front to back than its width from side to side. The facial index of Camper is approximately one hundred degrees, due to the bulging of the frontal region.

Fig. 25. Roentgenogram of lateral aspect of a hydrocephalic cranium. (8 month girl, Marquette University Hospital.) The facial index of Camper is approximately one hundred and twenty degrees due to frontal prominence. There is marked projection of the frontal region, overhanging the orbits, compared to the chin. The head long, broad and deep. The occiput is pushed backward and the skull is somewhat flattened at the top. Cranial content white due to decreased radiability caused by water density.

premature synostosis. The cartilage cells remain passive according to Keith and do not offer themselves as a sacrifice to the normal process of ossification; 14. the ethmoidal cartilage is normal in size in the subjects of achondroplasia; 15. the pre-sphenoid (orbito-sphenoid) and frontal elements continue to develop in achondroplasia; 16. the orbital and ethmoidal plates are depressed, thus causing an increased angulation at the junction of the basi- and pre-sphenoid. The chief increase

of cranial capacity is at the coronal suture; 17. the distance between the two internal auditory meatuses as well as the external is short and approaches infantile dimensions in achondroplasia; 18. the arrest in growth of the cartilaginous parts of the posterior fossa leads to an overgrowth of the membranous elements in the roof and sides of the skull.

Keith explains the characteristic features of the achondroplastic skull by an arrest of growth of the cartilaginous portion of the occipital bone in the posterior fossa. Jansen seeks for an explanation in a physical compression of the embryonic head.

At the metaphysis, intermediate cartilage or epiphyseal lines there is a structural arrangement providing for growth in length of long bones. The cartilage cells rapidly divide, assume a columnar arrangement, undergo hypertrophy and become vacuolated. These preparatory or pre-ossification changes in the cartilage cells do not take place in achondroplasia. There is neither rapid division, columnar arrangement, hypertrophy, nor vacuolation; there is an arrest of endochondral ossification, due to the failure of the normal growth of the metaphysis. The narrow zone of inactive intermediate cartilage, or metaphysis, is soon pervaded by the process of ossification and there results a premature synostosis between the epiphyses and diaphysis in the long bones. Growth in width is not inhibited but there is inhibition in the growth in length of the bone.

There is no discrepancy between the normal and achondroplastic cartilaginous extremities of the long bones; in the case of the skull cartilage is formed in almost undue amount. The deficiency relates to the length of the shaft of the long bones and not to the subperiosteal deposit on the surface; the rest is practically confined to the epiphyseal line. The cartilage cells adjoining the line of ossification are passive. The vascular loops and osteoblasts pierce their way into the passive cartilage to lay down new bone. This is a slow process according to Keith. The long bones and the cartilaginous occipital bone have the same lesion.

Keith has examined the pituitary, thyroid and testes in two cases of achondroplasia and according to him the pituitary fossa is small and the gland compressed, but allowing for the compression of the gland, the structure is not normal. There is a deficiency of the large eosinophilic cells. In the thyroid the cells lining the acini are irregular in shape and few in number. In the testes the seminal tubules are not filled, the larger genital cells are few, the intertubular tissue is made up of a more reticulated tissue than is usual, and contain fewer interstitial cells. Keith concludes that the theory which seems most likely to account for all of the symptoms of achondroplasia is the one founded on the action of internal secretion.

Opisthocephaly is the name applied to the skull by Keith which has the opposite characteristics to frontocephaly. There is a shortening of the anterior fossa of the skull with the result that the growth of the brain carries the skull in an upward and backward direction. The arrested growth is at the spheno-ethmoidal junction. The forehead slopes cephalo-dorsad and the face especially the jaws project prominently forwards, a pronounced prognathism. The major part of the skull lies behind the external auditory meatuses.

In acrocephaly there is a shortening of the base of the anterior cranial fossa of the skull, due to an arrest of growth at the spheno-ethmoidal junction. The base of the anterior fossa is also contracted. The shortening of the base of the skull is accompanied by a tendency for the process of ossification of membranous bones to invade the sutural line with the result that the growing margins of the bones fuse prematurely. This condition may also prove to be the result of a defect in the normal secretions.

In fronto-cephaly the posterior fossa is small, the anterior large; in opisthocephaly the posterior is large and the anterior small. The cause for these abnormal conditions is a disturbance of growth itself rather than mechanical compression of the embryo.

"Bull dogism" or snub nose or simoprosopia is the result of a profound aplasia of all of those bones laid down over the anterior part of the ethmoid or trabecular cartilages. The face is flat, the nasal bones are small nodules, the spine of the frontal appearing at the lower ends, the ascending maxillary processes project slightly in front of the lower border of the orbits, and the pre-maxillary regions of the upper jaw is drawn cephalad. There is a circumnasal atrophy and the palate bone is upturned.

Dorland and Hubeny ('26) state that the main cranial lesion of every achondroplast is an arrest of growth of the bones entering into the formation of the posterior cranial fossa. The skull is shortened and broadened as though the occiput and frontal bone were compressed toward each other.

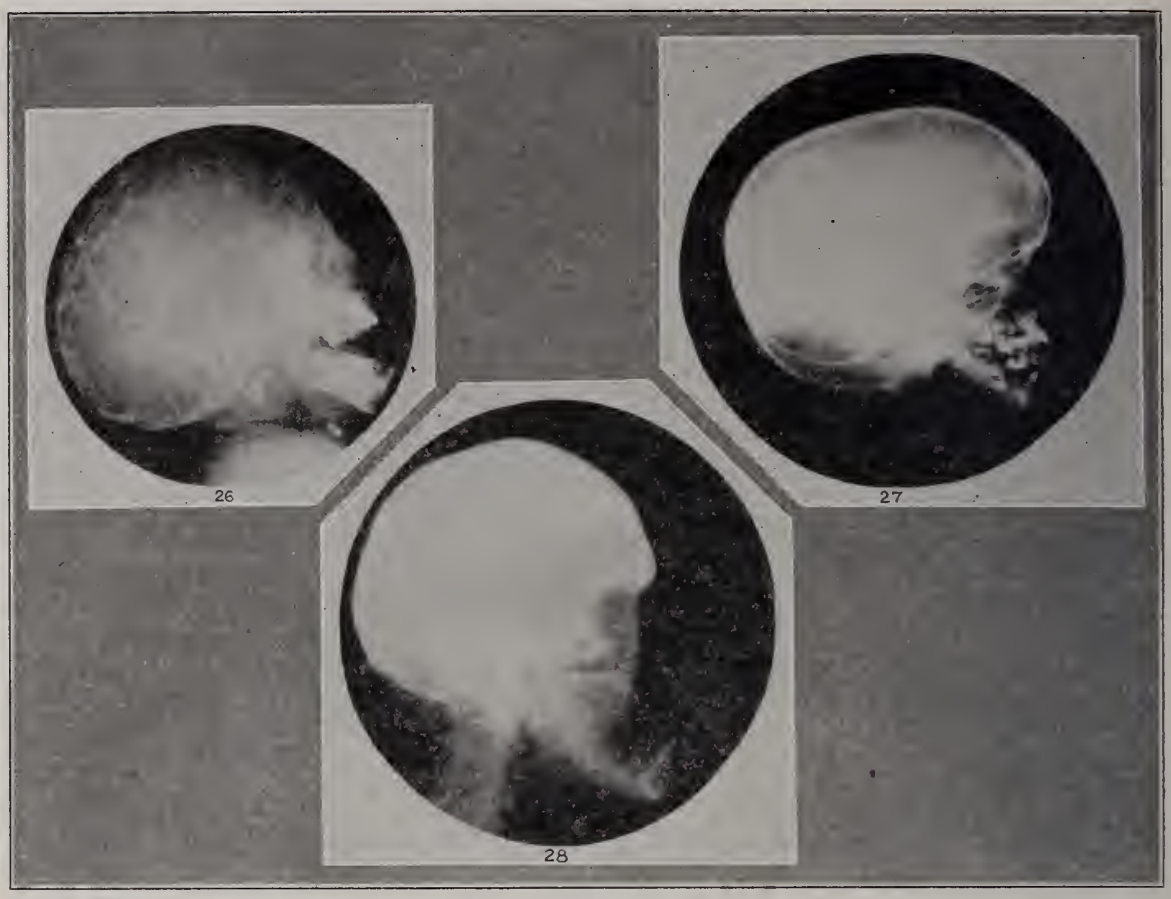

PLATE 5

Fig. 26. Roentgenogram of lateral aspect of oxycephalic cranium. (Three year old boy, Marquette University Hospital.) By radiographic inspection there is noted a thin contour of the calvarium; digital or putty finger impressions of the vault due to the gyri of the cortex of the brain; atrophy of the inner table of bone of the calvarium; hyper-ostosis between the impressions; frontal and mastoid sinuses fail to develop; orbits are shallow and the superior maxillary bone poorly developed; posterior cranial fossa occupies two-thirds of the base of the skull. (Compare this fact with the normal cranium.) Middle cranial fossa is deepened to the same level as that of the floor of the posterior cranial fossa instead of being step-like from above downward slantrum of Highmore is poorly developed and prognathism is present. There is increased density at the lateral side of the right orbit which represents an organized hemorrhage due to birth injury. Facial index of Camper, sixty degrees.

Fig. 27. Roentgenogram of the lateral aspect of an achondroplastic cranium. (Eight year old girl, Marquette University Hospital.) By inspection there is evident shortening of the basi-occipital and the basi-sphenoid; bulging of the frontal region (fronto-cephaly) caused by the brain seeking compensatory space due to the arrest of growth in the posterior fossa; the facial index is one hundred degrees.

Fig. 28. Roentgenogram of the lateral aspect of the acromegalic cranium. (Male, forty-five years old, Marquette University Hospital.) There is evident by inspection prognathism, decrease facial index, prominent supra-orbital ridges, enlargement of sella turcica and increased density of bone.

The hard palate is pushed backward and tilted up at its posterior end so that the naso-pharynx is narrowed or even closed. The face, therefore, assumes a "bull dog" appearance (simoprosopia), due to an arrest of growth and a thickening of the nasal bones. The foramen magnum and the vertebral canal may be flattened.

According to Jansen these symptoms of infolding are evidence of pressure which has acted on the head and tail ends of the foetus. Hydramnios is frequent at birth in these cases. The Sylvian aqueduct may be obstructed by the folding in of the brain leading to hydrocephalus. The normal physiological bending occurs about the third week of embryonic growth and at the sixth week straightening of the embryo begins again. It is assumed that the achondroplastic foetus undergoes the physiologic bending to an increased degree but never becomes properly straightened. Jansen concludes that the increased amnionic pressure

causes an increased condensation of the scleroblastemal, rapidly growing skeleton and that the vulnerability of these fast growing groups of cells explains all of the signs of achondroplasia. This condition is variously known, as, chondrogenesis imperfecta, chondrodystrophia foetalis, osteochondrodystrophia foetalis, fetal rickets and dwarfism.

III. THE OXYCEPHALIC CRANIUM (SYNOSTEOSIS CRANIA).

(Plate 5, Fig. 26.)

The sutures of the cranium normally begin to be obliterated at 40 years of age but this process is not completed until about 80 years of age. The cranial bones increase in size by growth at right angles to the long axis of the suture. When a suture is prematurely closed, growth at right angles to the line of the suture is stopped. Compensatory growth then occurs in other directions in the lines of least resistance.

If the sagittal suture be prematurely closed growth at right angles to the line of this suture is stopped. Compensatory growth occurs in a vertical and longitudinal direction, that is cephalocaudal and ventro-dorsad. The vault of the calvarium, therefore, is increased in height and elongated like an inverted skiff called scaphocephaly.

If the coronal suture be prematurely closed, growth is inhibited in a ventro-dorsal direction or at right angles to this suture line. Compensatory growth then occurs in an upwards or cephalic direction called oxycephaly or acrocephaly, (Hrdlicka '15).

If one-half of the coronal or lambdoidal sutures be prematurely closed there is failure of growth on that side in a ventro-dorsal direction or at right angles to the suture line. Compensatory growth leads to an oblique appearance of the calvarium called, plagiocephaly.

The tower or steeple skull may or may not have a marked prominence of the anterior fontanelle. Oxycephaly is variously known as, spitzkopf, turricephaly, acrocephaly, hypsicephaly, steeple or tower head, and crane en forme de tour. Türmschaedel is a condition in which there is a marked prominence of the anterior fontanelle.

There is no positive data as regards the etiology of this condition. According to Bertolotti and Meltzer rickets occurs in eighty-five per cent of the cases. Dock has presented little data regarding Lues as a factor. Virchow believes that venous congestion plays a role and Fletcher that the pituitary body may be disturbed in its function. Gudden has experimentally produced synostosis but no cranial deformity by ligating the jugular veins.

The order of frequency in the premature closure of the cranial sutures is as follows: 1. sagittal; 2. coronary; 3. tempero-sphenoidal; 4. parieto-sphenoidal; 5. lambdoidal; 6. parieto-occipital.

Fletcher has divided oxycephaly into three types; 1. congenital type in which exophthalmos and cranial deformity appears at birth; 2. these changes appear a few months after birth. 3. the child is practically normal for the first two years and between the second and sixth year the above signs of oxycephaly appear.

The three cardinal symptoms of oxycephaly are as follows: 1. A gradual and progressive impairment of vision; 2. exophthalmos; 3. characteristics cranial deformity.

The symptom of blindness is due to a post neuritic atrophy resulting from an arrest of the circulation in the sheath of the optic nerve. There is an increased intercranial pressure and a resulting choked disc precedes the atrophy.

The exophthalmos results from a shallow orbit. The eyeball continues to grow in the lines of least resistance and bulges outward. The great wing of the sphenoid forms the dorsal instead of the lateral orbital wall. There is limited mobility of the eyeballs. Divergence and convergence, strabismus is present as well as nystagmus.

By inspection the cranial deformity has the following characteristics: there is a high anterior fontanelle; the apex of which is just behind bregma; a reduction in the bi parietal diameter due to the abrupt drop of the parietal bones; a disproportion between the width and the height of the skull; obliteration of the superciliary ridges; flat malar bones. Prognothism is usually present. The intelligence is usually impaired.

By radiographic inspection there is noted a thin contour of the calvarium. There are digital or putty finger impressions of the vault due to the gyri of the cortex of the brain. There is atrophy of the inner table of bone of the calvarium. There is hyperostosis between the impressions which affect also the ethmoid and sphenoid. The vessel markings and the foramina of blood vessels are larger. The frontal and mastoid sinuses fail to develop. The orbits are shallow and the superior maxillary bone poorly developed. The sella turcica may or may not be enlarged. The posterior

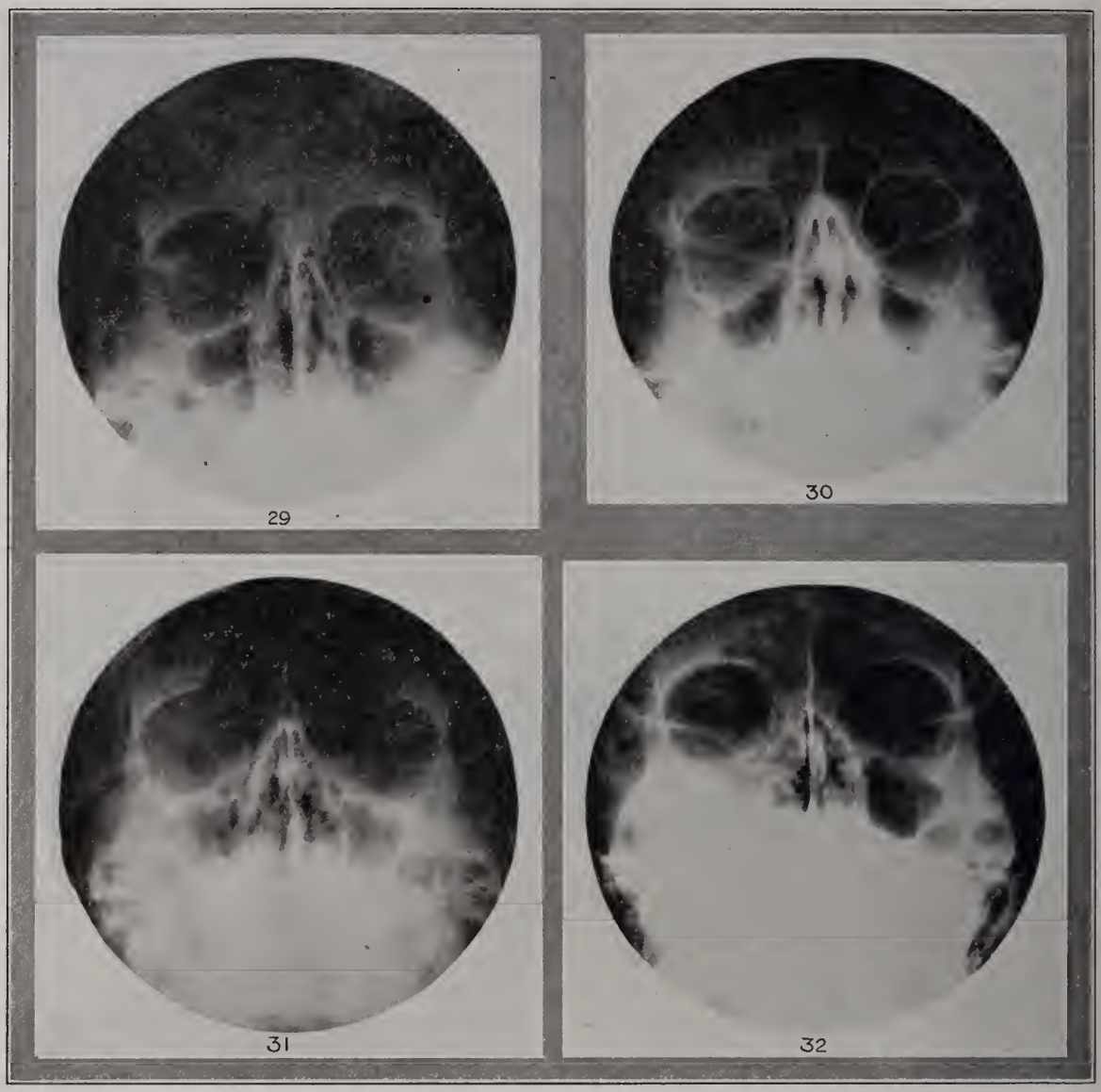

PLATE 6

Fig. 29. Congenital absence of the left frontal sinus.
Fig. 30. Bilaterally normal frontal sinuses.
Fig. 31. Asymmetrical frontal sinuses.
Fig. 32. Asymmetrical frontal sinuses with sinusitis of the right one.

cranial fossa occupies two-thirds of the base of the skull. The middle cranial fossa is deepened to the same level as that of the floor of the posterior cranial fossa instead of being step-like from above downwards. The temporal fossa is shallow and this region is pushed out laterally. The antrum of Highmore is poorly developed and prognathism is present. There may be areas of the calvarium of spontaneous decompression. There may or may not be present evidences of injury due to instrumental delivery resulting in abnormal overlapping of the cranial bones or an organized hemorrhage due to birth injury.

Virchow has classified cranial deformities arising as a result of premature synostosis into two types: 1. Brachiocephaly in which the skull is proportionately wider from side to side than from front to back. In this type the coronal suture is prematurely closed. Growth is inhibited from front to back or at right angles to the line of the coronal suture. Compensatory growth takes the line of least resistance from side to side and up and down; 2. dolichocephaly in which the skull is proportionately longer from front to back than from side to side. The sagittal suture is prematurely closed, growth is inhibited from side to

side at right angles to the line of the sagittal suture. Compensatory growth occurs from front to back and up and down in the lines of least resistance.

The incidents of oxycephalic cases in the literature has been largely in the male. The skull herein described is from a male.

According to Sutherland ('22) the symptom which brings the patient under medical attention is commonly impairment of vision. This may go on to complete blindness which is due to a post-neuritic optic atrophy. The arrest of the circulation of the fluids in the sheath and trunk of the optic nerves has been accepted as the most probable cause of oxycephaly. Bertolotti ('12) considers that this condition is due to a lymphatic disturbance on a rachitic base. Exophthalmos is seen in fifty per cent of the cases and is usually more prominent in one eye than the other. The lid symptoms of exophthalmic goiter are absent. Divergent strabismus is more common than the convergent type. Nystagmus and limited mobility of the globes are found. The increased height of the skull is more frequently found in the frontal than in the parietal region. The keel of the skull corresponds to the sagittal suture and the summit is just dorsal to bregma. The cranium is brachiocephalic, that is, wide in proportion to the length. Thickness of depressions along the line of the sutures may be seen. Obliteration of the superciliary ridges and unilateral flattening of the malars are common. The palate is short and high arched and prognothism are seen. The intelligence is unimpaired but the patient may look idiotic. Headache and convulsions may occur.

IV. ACROMEGALIC CRANIUM

(Plate 5, Fig. 28.)

Acromegaly is a disorder of growth characterized by increase in size of the face, extremities, and there is an associated perverted function of the anterior sympathetic lobe of the hypophysis or pituitary gland. If the disorder of growth occurs before the metaphysis fuses with the epiphysis and the diaphysis the results lead to gigantism, and on the other hand, if this growth disturbance occurs in adult life the result leads to an overgrowth of the skeleton due to sub-periosteal proliferation of bone. Acromegaly (Fig. 28).

The enlargement caused by sub-periosteal growth in the adult is most evident, in the jaw, hands and feet. The bones of the face are always involved manifested by an overgrowth of the orbital arches, frontal prominences; zigoma, malar, and nasal bones. The lower jaw is elongated resulting in prognathism; it is thickened and the teeth are separated. The roentgenogram has an enlargement of the sella turcica due to changes in the pituitary gland caused by hyperplasia, adenoma, fibroma, sarcoma, or cysts which cause distention of the Turk's Saddle of the body of the sphenoid bone. In late stages this results in pressure on surrounding structures particularly the optic chiasma. The symptoms of acromegaly are due to disfunction of the anterior lobe of the pituitary gland leading to the growth changes, subperiosteally and to the pressure caused by the enlargement of the anterior part of this gland.

The skin and subcutaneous tissues are thickened. Myxoedema or a flabby obseity may occur. Hypothyroidism has been found in one-third of the cases of acromegaly. The associated dis-function of the thyroid gland with gelatinous changes of the connective tissue is associated with wasting of the muscles.

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THE JOURNAL CLINIC

Chronic Inflammatory Hyperplastic Condition of the Alveolar Process of the Premaxillary Bone; Case Report

By M. N. FEDERSPIEL, M. D., D. D. S.
Milwaukee

Mrs. J. D., age 60 years, white, weight 140 pounds, occupation, housewife.

Complaint—pain in the maxillary and infraorbital regions.

History—Her general condition was good and she had enjoyed excellent health. During the past ten months she had had repeated attacks of pain in the upper jaw, especially so when she was lying down.

Examination—The alveolar process was found to be enlarged and protruding. On palpation the inner and outer plates would bend and felt springy. The teeth were slightly loose and on percussion there was a dull sound. $\frac{1}{1}$ had a broken down crown and the decayed root was covered with gum tissue. $\frac{3}{1}$ had been extracted. On pressure, pus and blood would ooze from the gingiva.

The anterior teeth were in pronounced infraversion. X-ray examination was negative except that the root of $\frac{1}{1}$ had a very clear circular area at the apex that was undergoing inflammatory changes. Transillumination of the enlarged alveolar process was very interesting. Instead of the clear illumination that one usually finds, there was a very dark, dense area surrounding each tooth.

Fig. 1. Showing enlarged and thickened alveolar process. Note infraversion of the upper anterior teeth.

Fig. 2. Showing hyperplastic condition of the alveolar process after the upper teeth were extracted.

Fig. 3. Showing the alveolar ridge after resection of the enlarged inflammatory growth. The soft tissues were carefully approximated so that the alveolar cul-de-sac was maintained and in order to avoid adhesions of the soft tissues to the crest of the alveolar border.

From the above findings I concluded that this patient was suffering from a chronic, diffuse, proliferative pericementitis (suppurative), and that this persistent irritation was the cause of the chronic, inflammatory, hyperplastic condition of the alveolar process. The pulps of all the teeth except $\frac{|}{|\ 1}$ were found to be vital.

The lower teeth remaining were $\frac{|}{8\ \ 32\ |\ 12345}$ These teeth were undergoing a chronic, gingivo pericementitis (suppurative). There were heavy deposits of tartar around the necks of the teeth and the subgingival spaces.

The patient was given surgical care in two stages.

In the first operation the maxillary teeth were extracted. The roots of the anterior teeth were covered with tufts of thick granulation tissue over about 1/3 of the area of the roots. The remaining area was bare. Between the tufts of inflammatory growth a thick, mucopurulent pus was found. The sockets were carefully explored and swabbed with glycero-iodine. The socket of the buried root of $\frac{1\ |}{|}$ had a large, circumscribed granuloma buried at the apex . The mass was shelled out.

The patient was given the usual post operative care and the wounds healed without any complications. Three weeks later the patient returned for the second operation. By this time the sockets had healed. The hyperplastic condition of the alveolar process seemed somewhat more pronounced now than before the teeth were removed. Figure 2.

The resection of the protruding bone was done sub-periosteally. The incision was made over the crest of the alveolar ridge, and the soft tissues were stripped from the bone so as to freely expose

Fig. 4. Showing the relaxation of the lips after operation. Notice the natural wrinkling.

all of the mass. The external bone plate was found to be very hard, resembling sclerosis. This was the result of persistent irritation. The bone mass was cut away with large, sharp, surgical burs, until the alveolar ridge conformed to an approximate normal size. Figure 3.

The flaps of soft tissue were proportionally reduced and sutured. The wound healed without any complications and the patient was able to wear artificial teeth comfortably. Figure 5.

Fig. 5. Showing the prosthetic restoration of artificial teeth. The proper preparation of the alveolar tissues facilitates the wearing of artificial teeth with comfort.

Diagnostic Problems

By L. M. WARFIELD, M. D.
Milwaukee

In the last Journal we had the case of a married woman, 35 years old, a farmer's wife, who had high diastolic and systolic pressure, rapid pulse and increased basal metabolic rate with functionally normal kidneys and no changes in the eye grounds.

DISCUSSION

This case was of particular interest to me because of certain rather unusual features. One would expect that with this high pressure there would have been more changes in the eye grounds, yet these were practically normal. The kidneys showed perfect functional capacity and yet there was a slight trace of albumin and a few granular casts. At this age group, 35, one would be tempted to call this a case of malignant hypertension and one would have a right to assume that the kidneys were affected, although so slightly affected that our tests showed normal function. However, cases of chronic glomerular nephritis and cases of essential hypertension as well do not show rapid pulse rate nor do they show any increase of basal metabolism unless there be some cardiac complication which would bring on dyspnea. With the increased work the metabolism is naturally increased. In this case there was no cardiac breakdown. The case then apparently belongs to a different group from those we are accustomed to see.

In 1925 Boas and Shapira reported some cases of high diastolic pressure with increased pulse rate and increased basal metabolism and considered that this was a group apart from the cases of ordinary hypertension. They reported also that both ligation of the thyroid arteries and subtotal thyroidectomy had been done on several of these patients with no beneficial result. On the contrary, one case was made very much worse.

In an attempt to determine whether increased intracranial tension might have something to do with this hypertension, a spinal puncture was done and fluid, under increased pressure, was found. Bearing in mind the possibility that certain tumors of the brain in the neighborhood of the pituitary might produce such a condition, the head was x-rayed with negative results. Tumor of the brain, as a possibility, was considered, but it was ruled out after neurological and x-ray examinations were negative.

This then seems to belong to the group of cases described by the authors above mentioned, and possibly, as they suggest, may have some relationship to disturbances of the endocrine glands. What glands are involved is impossible to say. The prognosis in such a case would depend largely upon the state of the kidneys.

We know so little about this group of cases that it is difficult to say what is going to happen to this particular woman. No form of treatment which I know has any effect upon these very high diastolic pressures. This woman was given advice in regard to her mode of life, diet, etc., but she was not prohibited from eating a certain amount of protein. I think we have evidence to show that a reasonable amount of protein in the diet has no effect upon blood pressure.

This case seems to me to be of particular interest and possibly now that attention has been called to the group, we may see more of these cases and by following them, as we have followed other groups of hypertension, we shall be able to give better prognoses and outline better methods of treatment.

A NEW PROBLEM

In the early part of May this year a young woman, school teacher, aged 35, unmarried, consulted me because of a pain in her lower right side. There was nothing of importance in her family history. She herself has usually had very good health, there having been no pelvic trouble. She had undergone several operations upon her nose for the removal of polyps and a frontal sinus operation a year ago. Several years ago she had her appendix removed following attacks of abdominal pain. For some years she had attacks of bronchitis every winter which have been better since the operation upon her nose, but she still has a chronic cough and every morning spits up a lot of phlegm, which she says if she does not get up makes her sick. About 10 years ago she had a hemorrhage from the lung. Sputum has been examined several times for tubercle bacilli, but none have been found. Her appetite is usually good, bowels regular. Menstruation began at about 14 years of age and has always been regular. Shortly after her appendix operation she again had pain in the lower right side which doubled her up. No fever or vomiting accompanied these attacks which were much like the attacks before the appendix was removed. There was no frequency of urination and they would last a day, coming irregularly 1 to 5 days apart. At that time a diagnosis of ureteral stricture was made following passage of ureteral catheters, and the ureter was dilated on two occasions.

She still has pain. However, it does not seem quite so severe. There are no pains in the back. She had no complaint about her appetite; she had lost seven pounds in the past few months.

On examination she was a tall, well-built young woman, well nourished, good color, clean tongue, splendid set of teeth. There was a slight asymmetrical thyroid enlargement. There were no glands palpable anywhere. There was slight limitation of expansion of the left side of the chest, the lungs, however, were clear on percussion and auscultation. The heart was normal in size and shape, and the sounds were normal. The abdomen was flat, there was a median scar below the navel. The left kidney was not palpable, the right was palpable and very slightly tender, but there was no pain over the floating ribs. In the right iliac fossa on deep palpation there was pain over the pelvic brim and a tender area just above Poupart's ligament. There was also the same pain and tenderness in the left iliac fossa, but possibly not quite so severe. The patient returned in the middle of June, saying that she still had pain in her abdomen and now she was sure that it was the middle of the right side. She admitted some selective dyspepsia, and that her bowels did not move as normally as they should. She had been urged to have her tonsils removed, although there was no very definite evidence of diseased tonsils. The ureter had not been dilated again.

On re-examination there was a very definite but slight stiffness of the upper right rectus muscle. Although there was no pain there was a distinctly uncomfortable feeling on palpation. With the hand pressed deeply under the ribs she could not take a deep breath. The edge of the liver was felt, sharp, not tender. Vaginal examination was negative. On close questioning she admitted that certain foods did not agree with her, especially sugars and starches gave her pain and every time she ate too much food she was distressed with gas and belching. She also remembered that she did have pain through to her right shoulder blade.

Fluoroscope examination of stomach with barium meal showed the stomach of J-shape, somewhat low, normal peristalsis, no filling defects, pylorus to the right of the middle line, emptying time quite normal, the duodenal cap was perfectly outlined with no indentations, but did not seem to be as freely movable as the normal. Urinalysis on several occasions showed no abnormalities.

The discussion of this case will be continued in next month's Journal.

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FOR THE COUNTY SOCIETY

1. *Program Material.* Pursuant to authorization by the 1924 House of Delegates the Secretary is arranging to make program material available without cost. The following can now be secured:

A. Departmental Officers of the State Board of Health. Address Dr. C. A. Harper, State Health Officer, State Capitol, Madison, Wis.

B. Clinicians of the Wisconsin Anti-Tuberculosis Association when in vicinity. Address Clinic Dept., W. A. T. A., 558 Jefferson Street, Milwaukee.

C. Councilors and Officers of the State Society. Address the individual.

2. *Annual Statements.* Uniform annual statements can be had without cost. Address the Secretary, advising number desired.

EDITORIALS

LARYNGEAL TUBERCULOSIS

A SHORT while back, a more than ordinarily interested, studious and competent physician declared laryngeal tuberculosis to be an incurable disease. The expert 1927 opinion is quite the opposite. How general such a pessimistic opinion may be among the practising physicians, we have no means of knowing. And perhaps, whatever there is of it is confined to the older men. They, it must be admitted, had far more reason for pessimism throughout the field of tuberculosis therapy than do the younger physicians. In any case, it seems justifiable publicly to correct the error.

Writing on the treatment of Laryngeal Tuberculosis, C. D. Parfitt of Gravenhurst, Ontario, says: "Laryngeal tuberculosis has been one of the less dangerous complications and the one most amenable to treatment. The lesion often becomes arrested or cured before the patient has recovered from the pulmonary disease, while even those with advanced laryngeal disease and bad prognosis may benefit greatly by active interference. The laryngeal complication has rarely proven fatal and then only in fulminant cases, or in those with an otherwise hopeless prognosis."

This is not far from the general concensus of opinion of the tuberculosis specialists and of the laryngologists who do not neglect the general sanatorium regimen while treating the local disease.—*H. E. D.*

PUBLIC HEALTH'S SEMI-CENTENNIAL

THIS is a year of celebration in recognition of a half century of organized public health work in Wisconsin. The Wisconsin State Board of Health was organized in 1876 by act of the legislature. An observance of this anniversary might have been held in 1926, but was deferred until this year to give time for planning a more suitable program in conjunction with the Wisconsin State Medical Society. With aims so interrelated, these two bodies will find many common levels of interest and cooperation when, at Eau Claire, next September 20-21, they hold their joint meetings. There is every incentive for a turnout of physicians and health officers surpassing any yet on record.

In retrospect the period encompassed by the Wisconsin State Board of Health since its establishment was a golden age in medicine and public health. Its triumphs in the fields of preventive medicine, pathology and surgery are hardly less striking than are the developments in creative science and invention in the same period. In a health way our State in the centennial year of 1876 was in the same relative status that our transportation methods held before the coming of the automobile. Popular conceptions of public health were, indeed, quite as provincial as were some popular opinions on the future of science in general.

To the medical men of 1876 the State Board of Health owes its origin. The law creating it was sponsored largely by a small group of physicians who were interested in preventive medicine. Only two states in the middle west—Minnesota, in 1872, and Michigan, in 1873—antedated Wisconsin in providing an organized health administration.

At the first meeting of the Board, on June 27, 1876, Dr. E. L. Griffin, of Fond du Lac, made this salutatory and prophecy: "Through the enlightened and liberal action of our legislature, Wisconsin has inaugurated a movement that may be made capable of good to her citizens in all future time. No statute of the state embodies greater wisdom or touches a more vital interest of the people than the one under which we act. To us is given the honor and upon us rests the responsibility of the initiatory health work of the state. It is for us to make the work of this Board popular with, because useful to, the people of the state."

The bill establishing the State Board of Health was introduced by Silas J. Seymour, of Reedsburg, member of the Assembly from Sauk County. The Board was composed of seven members appointed by the Governor and confirmed by the Senate. This system remains intact today, and is regarded by sanitariums generally as the most practical plan for effective state health administration.

Although they knew what the state needed, the public health pioneers of 1876 were doubtless not even distantly aware of the great scope which the state's health program was to assume in the decades to follow. In that day there was not even the germ of a scientific system of vital statistics registration, nor was a chain of public health laboratories dreamed of by those who founded the present organization. Quarantine measures were a long time later to be proposed, much less adopted. All these and more were to be the outgrowth of public health administration as the state grew in population and complexity of problems.

As indicated, the period through which the State Board of Health has lived has witnessed wonderful developments for the alleviation of human afflictions and the extension of the life span. Local anaesthesia, for example, was not given to the world until 1884. Koch discovered the bacillus of tuberculosis and cholera, greatly expanded the science of bacteriology and advanced materially the science of infectious diseases; Roentgen discovered the x-ray; yellow fever passed as an American peril through the achievement of Gorgas in Panama; Trudeau's successful experiment in the outdoor treatment of tuberculosis and the development of the sanatorium were to become known also in the latter part of the century. The control of diphtheria, scarlet fever, typhoid fever, and other diseases of previous large destructiveness became a fact. The elevation of nursing as a standardized profession and its share in the relief of the afflicted were synonymous with the great advance made in medicine and hygiene in the same epoch.

The State Board of Health invites the physicians of Wisconsin to join in these sessions at Eau Claire, to re-read the pages from the state's health history, and to glimpse the future in which, we are sure, still more remarkable progress in public health is yet to be made.—*C. A. H.*

ITINERANT PRACTITIONERS

THAT the practices of itinerant physicians may constitute an actual health menace is the timely comment and warning contained in the last State Board of Health Quarterly. Because of the importance of this subject we re-publish the statement here:

"Wisconsin has seen fit to be strict with her citizens when there is apparent danger of spreading communicable disease. We quarantine homes having dangerous ills of infective character. We isolate the patient, and when necessary to protect the public by so doing we confine the exposed person to the limits of the quarantined home. The question "To quarantine or not to quarantine?" is decided in the affirmative, with the suspected patient getting the short end of the argument, rather than subject schoolmates, neighbors, and the general public to the same disease. When in doubt, government decides in favor of the larger number.

"There are occasions in some of our Wisconsin cities when safety first precautions might well be enforced also in hotels. There are some few physicians who follow the method of traveling from city to city, spending a day or more at an advertised hotel and receiving patients in guest or sample rooms. Visitors to these practitioners use the halls and lobby as waiting rooms.

"While such advertising in the main refers to chronic diseases, the appeal is by no means limited to that class of the sick. Even though thus limited, it is safe to assert, the appeal brings many a case of venereal disease and tuberculosis. Diseases of a chronic character these may be, but every good physician also recognizes their true nature so far as the public safety is concerned.

"It may be suggested purely in the interest of the public good that the temporary use of rooms, subsequently used by the traveling public, as a physician's office and the resulting close contact between the traveling public and the sick is not a good policy for either the public or the hotels.

"Health officers might well present this condition to their local hotel men, pointing out the intent of the law as specified in Section 131.04 of the statutes.

"It is true that some physicians have permanent offices in hotel buildings. So long as such rooms are used exclusively for this purpose and include waiting room facilities, there is perceived no danger of any consequence from this source.

"The thoughtful hotel operator will recognize an opportunity here to shield his guests and the larger public from any possible chance of contagion and loss."

THE PRESIDENT'S PAGE

Arthur W. Rogers

ABUSE OF THE FREE DISPENSARY

ONE hears and reads much these days concerning the need of educating the public relative to the standards, ethics, and general activities of the medical profession. Indeed, it would appear that one of the chief indoor sports of certain laymen is to call attention to our foibles and mistakes, and to point out the need of our wiseheads getting together to save us from revolution and destruction.

Out of all this smoke there is no inconsiderable amount of fire, and it is evident to many physicians that our profession is passing through a transitional stage which we firmly believe will be weathered.

We have as yet heard no layman mention the lamentable fact that the average physician is greatly underpaid for his services, that no class of men give so freely and liberally of their time and effort, and that few physicians who have practiced medicine for twenty-five years could retire and live comfortably on their savings.—Why?

Last year eight million of our people were treated gratuitously in our "free" clinics and hospitals. This does not include other tens of thousands treated by our colleagues in offices and homes for which no monetary return was expected or received.

This deliberate cheapening of the doctor's services by this universal trend toward free medical attention is lowering his prestige. Whatever is free is not appreciated. The day has arrived when people who come to our dispensaries and free clinics in furs and other finery, or drive up in taxicabs or their own palatial cars, should have some rather pointed questions put to them not directly connected with their state of health. "Charity clinics" is preferable to the prefix "free". Such clinics should be reserved for only the destitute and those unable to pay for services. Let the patient designate his financial status in his own handwriting.

There is no other profession or group of men against which there has been launched so many attacks to lower his income as against the medical man. The physician is inherently a poor salesman, and unless the public can come to appreciate and prefer the modern scientific physician to the doctor of twenty-five years ago we as a profession will be almost compelled to resort more to methods of art and salesmanship than to scientific procedure.

The public must be brought to realize what is necessary today to secure a medical education and practice. That the modern practice of medicine requires many expensive accessories and that our overhead is great.

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Dane	W. D. Stovall, Madison	Hans H. Reese, Madison.
Dodge	L. M. Bachhuber, Mayville	A. A. Hoyer, Beaver Dam.
Door	John Hirschboeck, Forestville	T. C. Proctor, Sturgeon Bay.
Douglas	P. G. McGill, Superior	J. W. McGill, Superior.
Eau Claire and Associated Counties	G. W. Beebe, Eau Claire	H. M. Stang, Eau Claire.
Fond du Lac	D. N. Walters, Fond du Lac	H. R. Sharpe, Fond du Lac.
Grant	E. C. Howell, Fennimore	M. B. Glasier, Bloomington.
Green	J. L. Fleck, Brodhead	J. F. Mauermann, Monroe.
Green Lake-Waushara-Adams	Orvil O'Neal, Ripon	J. M. Johnson, Ripon.
Iowa	A. D. Brown, Mineral Point	M. W. Trentzsch, Highland.
Jefferson	W. C. Becker, Watertown	A. C. Nickels, Watertown.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	C. G. Richards, Kenosha	H. A. Binnie, Kenosha.
La Crosse	E. A. Smedal, La Crosse	N. P. Anderson, La Crosse.
Lafayette	W. W. Peck, Darlington	S. A. J. Ennis, Shullsburg.
Langlade	M. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	E. K. Morris, Merrill	W. H. Bayer, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	M. P. Andrews, Manitowoc.
Marathon	W. E. Zilisch, Wausau	Verne F. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	M. D. Bird, Marinette.
Milwaukee	C. H. Stoddard, Milwaukee	E. L. Tharinger, Milwaukee.
Monroe	H. B. Johnson, Tomah	H. H. Williams, Sparta.
Oconto	C. W. Stoelting, Oconto	C. J. Ouellette, Oconto.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schick, Rhinelander.
Outagamie	J. B. MacLaren, Appleton	C. D. Neidhold, Appleton.
Pierce-St. Croix	Rolla Cairns, River Falls	J. W. Prentice, Deer Park.
Portage	G. H. Lawrence, Stevens Point	F. R. Krembs, Stevens Point.
Price-Taylor	E. A. Riley, Park Falls	J. D. Leahy, Park Falls.
Racine	W. A. Prouty, Burlington	Susan Jones, Racine.
Richland	J. M. Ross, Richland Center	G. Benson, Richland Center.
Rock	W. H. McGuire, Janesville	H. E. Kasten, Beloit.
Rusk	L. M. Lundmark, Ladysmith	H. C. Johnson, Bruce.
Sauk	H. J. Irwin, Baraboo	Roger Cahoon, Baraboo.
Shawano	R. C. Cantwell, Shawano	C. E. Stubenvoll, Shawano.
Sheboygan	C. A. Squire, Sheboygan	G. J. Juckem, Sheboygan.
Trempealeau-Jackson-Buffalo	George Christiansen, Galesville	R. L. MacCornack, Whitehall.
Vernon	H. J. Suttle, Viroqua	Wm. H. Remer, Chaseburg.
Walworth	B. J. Bill, Genoa City	T. P. Keenan, Lake Geneva.
Washington-Ozaukee	C. A. Balkwill, Grafton	A. H. Heidner, West Bend.
Waukesha	C. C. Edmondson, Waukesha	J. F. Wilkinson, Oconomowoc.
Waupaca	T. E. Loope, Iola	A. M. Christofferson, Waupaca.
Winnebago	S. D. Greenwood, Neenah	R. H. Bitter, Oshkosh.
Wood	J. C. Hayward, Marshfield	V. A. Mason, Marshfield.

SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

A summer meeting of the Brown-Kewaunee County Medical Society was held Thursday, July 21st, at Kewaunee. A chicken dinner was served at 6:30. Dr. F. Gregory Connell, of Oshkosh, presented an interesting paper on "Gall Bladder Disease"; discussion followed. Physicians from Manitowoc, Two Rivers, Sturgeon Bay and Green Bay were in attendance. *M. H. F.*

CLARK

The Clark County Medical Society held its annual meeting at Dorchester on July 14th. Subjects of vital importance to the society were thoroughly discussed during the dinner hour.

Dr. S. G. Schwarz, Marshfield, was elected president for the ensuing year and Dr. F. P. Foley, Dorchester, secretary-treasurer. The following members were in attendance: Drs. Jackey and Neis, Thorpe; Schwarz and Mason, Marshfield; Schemmer, Colby; Rath, Granton; Howsley, Neilsville; Treadwell, Withee; and Foley and Schif, Dorchester. *F. P. F.*

KENOSHA

The members of the Kenosha County Medical Society enjoyed their annual picnic this year at Brown's Lake on July 27th. Dinner was served at six o'clock at the Antler's Hotel. Golfing, boating, swimming and bridge provided the recreation. *H. A. B.*

MARINETTE-FLORENCE

Dr. Frederick J. Gaenslen, Milwaukee, conducted an orthopedic clinic at the Marinette High School on July 23rd. About seventy-five cases, which included a large variety of orthopedic deformities, were represented.

The clinic was held under the auspices of the members of the Marinette-Florence County Medical Society, who were addressed by Dr. Gaenslen in the evening, following a six-thirty o'clock dinner at the Old English Grill. *M. D. B.*

ROCK

The regular June meeting of the Rock County Medical Society was held at the Beloit Y. M. C. A., Tuesday evening, June 28th, with forty-five physicians and five guests present. President McGuire called the meeting to order after a splendid chicken dinner. A clog dancing act by three children was put on under the direction of Dr. Schram. The minutes of the preceding meeting were read and approved. Dr. Belting reported on the dairy farm inspection trip.

Following the business session, the meeting was turned over to Dr. R. C. Hartman, chairman of the section on pediatrics, who introduced Dr. Clifford Grulee of Chicago, who gave an address on "The Anemias in Infancy and Childhood". The address was discussed freely, especially by Drs. Woodward and Krause of Rockford, specialists in pediatrics. Dr. H. M. Helm gave an interesting discussion on "Vomiting in Infancy", citing a case of pyloric stenosis which was successfully operated. This address was also thoroughly discussed. Dr. Beveridge, president of the Ogle County Society, spoke briefly, after which Dr. Christianson, president of the Winnebago County Society, invited the Rock County Society to a joint picnic. A committee consisting of Drs. W. J. Allen, F. W. Leeson, and H. E. Kasten were appointed to work with the Rockford committee in choosing site and making necessary arrangements. The meeting was adjourned until September 27th. *H. E. K.*

TREMPEALEAU-JACKSON-BUFFALO

On May 31st the Trempealeau-Jackson-Buffalo County Medical Society met at Whitehall. Dr. Edward Evans, of La Crosse, gave an interesting talk on the progress of medicine during recent years. Dr. R. E. Flynn, secretary of the State Board of Medical Examiners, and Mr. William Krause, attorney of La Crosse, spoke on the work being done by the Board of Medical Examiners against quacks, abortionists and illegal practitioners in Wisconsin. After the meeting a chicken dinner was served at the home of Dr. MacCornack.

The society held a joint meeting with the Tri-County Dental Society at Independence on June 24th. Dr. L. T. Austin of the Mayo Clinic, Rochester, Minnesota, and Dr. John Meissner, Cleveland, Ohio, were the principal speakers and discussed "The Teeth as Foci of Infection," giving the results of many experiments carried on at the Mayo Clinic. The talks were illustrated with lantern slides and were well received by the joint societies. It seems probable that the meeting of the doctors and dentists will be an annual affair. *R. L. MacC.*

WAUKESHA

Dr. W. R. Notbohm, Dousman, was host to the members of the Waukesha County Medical Society on Wednesday, July 6th. Dr. Francis D. Murphy, of the Milwaukee County Hospital, addressed the meeting on the subject of "Kidney Diseases". *J. F. W.*

WINNEBAGO

Dr. E. L. Miloslavich, Milwaukee, presented an interesting paper on "What Can We Learn From Post Mortem Examinations" before the Winnebago County Medical Society on Thursday evening, June 30th. *R. H. B.*

GREEN BAY ACADEMY

The annual meeting of the Green Bay Academy of Medicine was held at the Hotel Northland Friday evening of June 24th. Dr. William Allen Pusey of Chicago spoke at the banquet held in the Crystal Ball Room at six-thirty. Dr. Pusey is a past president of the American Medical Association and an eminent authority on skin diseases. His paper stressed the late developments in the treatment of syphilis.

Dr. E. G. Nadeau, Green Bay, was elected president of the Academy; Dr. R. L. Cowles, vice president; Dr. O. A. Stiennon, secretary-treasurer, and Drs. E. S. Knox and T. J. Oliver, directors.

FIFTH DISTRICT

Physicians from all parts of the state, but especially from Sheboygan County and vicinity, gathered at Elkhart Lake on June 30th and July 1st for the annual meeting of the Fifth Councilor District Medical Society. Outdoor sports and other forms of recreation were on the program previous to the evening banquet. A golf tournament was the main event of the afternoon, with bridge for the ladies.

President Glenn Frank of the University of Wisconsin was the principal speaker at the banquet. He issued a challenge to the general medical practitioners in Wisconsin to develop a leadership within their profession which will handle their own situation, to merge the good qualities of the art of medicine as practiced by the old-time physician with the newer science of medicine, and not to leave this development in the present critical period of readjustment to vast organizations of state medicine as developed by industries, insurance companies, and state and federal government. Dr. Arthur W. Rogers, president of the State Society, spoke on "The State Medical Society and Its Functions". The remainder of the evening was spent in dancing.

The following program was presented on Friday, July 1st: Dr. Friedrich Eigenberger, Sheboygan, "Experiments with Rattlesnake Venom"; Dr. Wilber E. Post, Prof. of Medicine, Rush Medical College, Chicago, "Diseases of the Kidney"; Dr. Paul B. Magnuson, Asst. Prof. of Surgery, Northwestern University Medical School, Chicago, "Treatment of Fractures"; Dr. C. A. Harper, Secretary of the State Board of Health, Madison, "Periodic Examinations of the Apparently Healthy"; Dr. Otto Foerster, Prof. of Dermatology, University of Wisconsin, "Ringworm Infection of the Hands and Feet; A Common and Usually Unrecognized Dermatosis"; Dr. G. V. I. Brown, Prof. of Plastic Surgery, University of Wisconsin, "Plastic Surgery of the Present Day as Relating to Practitioners of General Surgery"; Dr. Joseph P. McMahon, Milwaukee, "The Experiences and Responsibilities of the Medical Profession with the Cancer Problem".

The meeting was pronounced a success from every standpoint. Dr. O. B. Bock, Sheboygan, is councilor for the Fifth District.

NEWS ITEMS AND PERSONALS

Dr. Gilbert Seaman, a delegate of the United States Army Medical Service to the Fourth International Congress on Military Medicine at Warsaw in June, has received the insignia and certificate of "Honorary Graduate and Honorary Professor of the Military Medical School of Poland". This distinction was bestowed upon Col. Seaman at a formal review. Dr. Seaman left Warsaw following the congress to take up special work in internal medicine and neurology at Vienna.

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Dr. Ivan G. Ellis, formerly of the staff of the Wisconsin University Medical School, is at present assisting Dr. J. A. Mudroch in his practice at Columbus.

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Representatives of Kenosha industries assembled recently at a meeting called by the local anti-tuberculosis association for the discussion of tuberculosis prevention in factories. Dr. Hoyt E. Dearholt, state executive secretary of the Wisconsin Anti-Tuberculosis Association, and Dr. A. A. Pleyte, also of the Association, gave suggestions and helped formulate plans for further prevention of the disease.

Dr. Louis Milson, of Green Bay, has taken over the office of Dr. J. A. Muelhauser, De Pere. Dr. Muelhauser sailed for Europe a short time ago.

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Dr. Gentz Perry, Kenosha, has become associated with the Schiek Clinic at Rhinelander, where he will direct and operate the radiological department. He has also accepted the position of roentgenologist to St. Mary's Hospital in that city.

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That the twenty tuberculosis sanatoria of the state have for the first time in their history practically no vacant beds because of the lack of exodus of winter patients to their homes, was the conclusion made at the Seventh Annual Midyear Sanatorium Conference at Riverview Sanatorium, Little Chute, on June 25th. The conference was attended by seventy-five physicians, nurses, superintendents, and members of boards of trustees from twelve sanatoria.

With the conference sponsored by the Wisconsin Anti-Tuberculosis Association and with Dr. C. D. Boyd as the general chairman, the morning program was devoted to the discussion of the three following topics: "Rehabilitation of Ex-Tuberculous Patients"; "Duties of Members of the Boards of Trustees of County Sanatoria"; and "Follow-Up of Sanatorium Patients". The talk given by Col. John J. Hannan, president of the State Board of Control, was a careful study of the background of the laws which affect the duties of members of boards of trustees.

Mrs. A. P. Lawin, superintendent of the Franklin County Sanatorium, Columbus, O., was the principal speaker of the afternoon program. Besides the round table discussion at which she spoke, there were also discussions for nurses, trustees, physicians, as well as one on rehabilitation.

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Dr. T. A. Hagerup, Madison, left recently for an extended European trip, on which he plans to visit clinics in Germany and France. He will visit first with his parents in Norway and expects to return to the United States in about two months.

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Members of the Oshkosh Kiwanis Club were urged to obtain a better understanding of the adolescent child in an address delivered before the club during the latter part of June by Dr. S. M. Kyes, local physician. Dr. Kyes discussed this subject from several angles and made a thorough and minute analysis of the characteristics and peculiarities of the adolescent.

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Dr. Kenneth A. Swartz, Milwaukee, has become associated with Dr. F. T. Clark in the practice of medicine at Waupun. Dr. Swartz is a graduate of Marquette Medical School and served his internship at the Milwaukee County Hospital at Wauwatosa.

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Dr. A. M. Carr terminated his duties as city health officer of Madison on July 1st. Dr. Louis Fauerbach, former assistant city health officer, was named to succeed him temporarily.

A well attended and very interesting institute on "The Nutritional Problems of Children", under the direction of the Wisconsin State Board of Health and assisted and sponsored by the members of the Milwaukee Visiting Nurse Association, met in Milwaukee from June 20th to July 2nd. The institute was directed by Dr. William R. P. Emerson and Miss Mabel Skilton, both of Boston, Mass. Besides the course given at the nutrition headquarters, there were also lectures and demonstrations given with various groups of children at different points in the city, which were attended by the ninety attendants at the institute.

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Dr. L. J. Friend, who during April took over the practice of Dr. L. J. DeSwarte, of Beloit, has announced that he will reopen his practice in Merrill. Dr. Friend specializes in diseases of the eye, ear, nose and throat.

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Dr. C. M. Medlar, professor of pathology at the University of Wisconsin, has resigned from the faculty to engage in medical research at the laboratories of the New York Mutual Life Insurance Company, at Mount MacGregor, N. Y.

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Dr. Frank L. Weston, who has been a member of the student medical advisory staff at the Wisconsin General Hospital, has resigned to establish a private practice. He has opened offices in the First Central Building, Madison.

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The government has broadcast a call, through its civil service representatives, for medical officers to fill vacancies in various branches of the federal service, and specialists in practically all the divisions of medicine and surgery are sought, according to a recent report issued by the board.

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Two years ago, at the request of Mr. Aubrey Williams of the State Conference of Social Workers, a number of cities were appraised by the State Board of Health upon public health activities. A standard score sheet devised by the American Child Health Association and with the endorsement of the United States Public Health Association was used. Just at present the State Board of Health has extended this work and Dr. Frank Bowman is making a similar appraisal of some of the smaller cities in Wisconsin. No adequate standard score sheet for cities of this class has been obtainable and the state department has devised one of its own. In making these appraisals it is hoped to point out to the various small towns their public health deficiencies as compared with a reasonable standard and as compared with each other.

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Dr. E. L. Miloslavich, director of the department of pathology and bacteriology, Marquette University School of Medicine, was invited to address the midsummer session of the Austin Flint-Cedar Valley Medical Society, at Cedar Falls, Iowa, July 13th, on the subject of "Tumors of the Kidney".

Dr. and Mrs. F. Gregory Connell and children, Miss Jane and Charles Connell, left Oshkosh about the first of August for New York City and on August 6th sailed from New York on the Majestic for Cherbourg, France. They will spend about six weeks abroad, visiting in France, Switzerland and England. Upon returning to this country both Miss Jane and Charles will remain in the east, where they will attend school next year.

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Dr. A. A. Charbonneau, Green Bay, has returned from Chicago, where he recently completed a post-graduate course in the treatment of eye, ear, nose and throat at the University of Illinois, and from now on he will specialize in this branch of medicine.

Dr. Charbonneau has been engaged in the practice of medicine and surgery for the past fifteen years and for the past five years he has devoted his time to the study of the eye, ear, nose and throat. He is a graduate of Illinois and served his interneship at the Los Angeles County Hospital.

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The evils caused by the use of worthless patent medicines was the topic upon which Dr. A. S. Loevenhart, professor of pharmacology and toxicology at the University, lectured recently at Science Hall.

"A patent means a discovery and patent medicines are not discoveries but simply copyrighted names," said Dr. Loevenhart. "Most patent medicines do not contain ingredients that will aid the patient but are composed of cheap materials such as salt, water, sugar, and coloring matter."

MARRIAGES

Dr. F. R. Krembs, Stevens Point, to Mildred Bard, also of Stevens Point, at Clintonville on June 16th.

DEATHS

Dr. James W. Frew, Milwaukee, surgeon, athlete and military leader, died on July 8th, a victim of a prolonged illness brought on by having been gassed three times during the world war, in which he served as a lieutenant colonel of the medical corps.

Dr. Frew was born in Glasgow, Scotland, in 1870 and was graduated from the Milwaukee Medical College in 1899. In his early life Dr. Frew was an athlete of national repute. He was decorated with the French Croix de Guerre following a notable achievement in the St. Mihiel drive.

The deceased is survived by his wife, a son and a daughter. He was a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Dr. Norman W. Hollenbeck, Milwaukee, died on June 23rd at his home. Dr. Hollenbeck had been in failing health for several years and suffered a nervous breakdown a short time before his death which forced him to give up his practice temporarily.

The doctor was born in Ripon in 1874 and obtained his early education there. After graduating from Beloit College he studied medicine in the Wisconsin College of

Physicians and Surgeons, Milwaukee, which course he completed in the year 1904. Besides his wife, he is survived by two sons and two daughters.

Dr. Hollenbeck was a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Dr. Peter MacDougall, Waukau, died at his home in that village on June 10th, following a prolonged period of ill health. He had spent more than a month in Mercy Hospital, Oshkosh, and was brought to his home just recently.

Dr. MacDougall was born in 1851 and was a graduate of the National Medical University, Chicago, in 1898. He practiced medicine in Seattle, Wash., and in Minnesota before coming to Waukau. His wife, two brothers and two sisters survive him.

Dr. George H. Fay, Whitewater, died on June 30th, following a lingering illness. He was born at Byron, January 17, 1860, was graduated from Hering Medical College in 1913 and a year later from the Chicago College of Medicine and Surgery. He is survived by his wife and one daughter.

Dr. James R. Kingsley, Three Rivers, Michigan, died on June 30th while at work at the former Three Rivers Hospital. Dr. Kingsley practiced medicine in Sheboygan from 1897 until 1915 and served as president of the Sheboygan County Medical Society a short time before his departure. The deceased was born in Michigan on June 5, 1869, and was a graduate of the Michigan University School of Medicine in 1897.

Dr. Alva L. Allen, Norwalk, died suddenly on June 14th from heart disease while driving his automobile. Dr. Allen was 59 years of age and was widely known in southern Wisconsin, having practiced in that territory for many years before his retirement. He is survived by his wife and three sons, one being Dr. J. S. Allen, who is now in practice at Norwalk.

Dr. Alfred G. Kreutzer, Milwaukee, died on Wednesday, June 29th, at his home after suffering for nearly a year from a heart affliction. Dr. Kreutzer was born at Grafton in 1877 and spent all of his life in Wisconsin. He was graduated from the Wisconsin College of Physicians and Surgeons, Milwaukee, in the year 1902 and since then has practiced his specialty in Milwaukee in addition to his work as director and clinical professor of eye, ear, nose and throat surgery at Marquette University.

Dr. Kreutzer spent two years in medical study at Vienna in 1910-1911 and several years later returned to Europe for post-graduate work at Berlin, Vienna, London and the Scandinavian countries. The deceased is survived by his wife and a daughter. He was a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Dr. Louis M. Bachhuber, Mayville, died at St. Agnes' Hospital at Fond du Lac on July 19th, following a major operation about ten days ago. Dr. Bachhuber was born in Leroy, March 5, 1870. He attended the Mayville High School and later entered Northwestern University, where he studied medicine and graduated in 1893. He returned to Mayville, where he opened a practice that was continued until his death.

Dr. Bachhuber was president of the Dodge County Medical Society at the time of his death. He had been a member of this society for many years as well as of the State Medical Society of Wisconsin and the American Medical Association. He is survived by his wife and one daughter.

Dr. Frank O. Risher, Shell Lake, died at the hospital at Cumberland, Wednesday evening, July 13th, from gastro-enteritis. The deceased was born January 2, 1880, and was graduated from McGill University Faculty of Medicine, Montreal, in 1906. Dr. Risher served his interneship at St. John's Hospital, Pittsburgh, was licensed in the state of Wisconsin in the year 1908 and has practiced his profession at Shell Lake continuously since that time. Surviving him are his aged mother, his wife and a son and daughter.

CORRESPONDENCE

"PAYS TO ADVERTISE"

Dr. Gustav Kaumheimer, attracted by appeals of the Wisconsin Anti-Tuberculosis Association for State Board of Health Reports necessary to complete its file, has located some of his old copies and contributed them to the W. A. T. A. Library.

This addition leaves only four reports still to be obtained. Who has the following numbers and would care to contribute or loan them to the W. A. T. A.?

No. 10—1886
No. 12—1888
No. 13—1889-90
No. 18—1899-1900

Aimee Weinstock,
Wisconsin Anti-Tuberculosis Ass'n.,
558 Jefferson St., Milwaukee.

UROLOGICAL MEETING

North Central Branch of American Urological Association,

Eau Claire, Wis., June 22, 1927.

Dear Doctor:

The North Central Branch of the American Urological Association will hold its meeting this year at Madison, Wisconsin, on Friday and Saturday, October 14th and 15th. Only Saturday morning will be utilized for the meeting, as we are all planning to go to the Michigan-Wisconsin game in the afternoon.

An interesting and instructive program is being arranged and we are anxious to have a large attendance. This letter is merely a preliminary announcement so that you may bear the dates in mind and plan accordingly.

To those who are graduates of the University of Wisconsin or Michigan, we would advise that you secure your tickets for the game early, also make your reservations at the hotels early, before August 15th. Secure as many tickets as the rules will permit. Please advise me as soon as possible if you are planning to go and if you have ordered tickets and made reservations.

To those who are not graduates of the University of Wisconsin or Michigan, we wish you would write as

soon as possible so that we may know how many tickets to secure and how many hotel reservations to make before the first of September. We are anxious to show you a good time and help you to be comfortable while in the city. The hotel accommodations are limited as thousands of people will be back for the game.

A statement is enclosed of the amount of dues which are unpaid. A check by return mail will be greatly appreciated.

Yours very truly,
H. M. Stang,
Secretary-Treasurer.

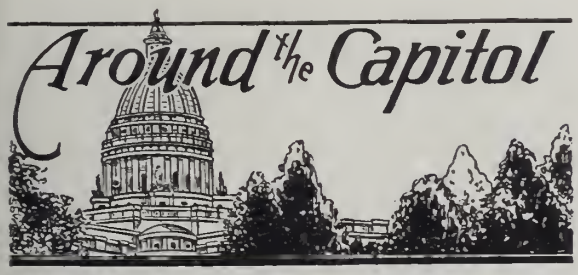
SOCIETY RECORDS

New Members

Flarity, Thomas H., 410½ State St., Beloit.
Wink, R. H., Granton.
Wagoner, F. F., Clayton.
Bachinski, L. J., 141 E. Wisconsin Ave., Milwaukee.
Herman, A. H., Woodruff.
Johnson, Frances, 141 E. Wisconsin Ave., Milwaukee.
Mailer, A. R., 141 E. Wisconsin Ave., Milwaukee.
Ziegler, C. K., 3426 Vliet St., Milwaukee.
Wallner, Adolph, Watertown.
Haddow, N. W. Chippewa Falls.
Milson, Lewis, 375 Main St., W. DePere.
Geist, F. D., University of Wisconsin, Madison.

Changes in Address

Perry, Gentz, Kenosha, to Schiek Clinic, Rhinelander.
Walker, L. J., New York City, to Wykoff, Minn.
Heifetz, E. C., Wauwatosa, to 1083 Teutonia Ave., Milwaukee.
Fogo, H. M., Madison, to Richland Center.
Sathe, M. R., Fond du Lac, to Sweet Clinic, Centralia, Wash.
Desbois, P., Marinette, to Peshtigo.
Boner, A. J., Mendota, to 10 E. Gorham St., Madison.



Cases of alcoholic insanity in Wisconsin are about as numerous as they were in the days before prohibition, but cases of delirium tremens have become scarce, and Dr. Adin Sherman, superintendent of the Northern Hospital for the Insane, believes that the absence of the latter disease is due to the failure of liquor addicts to get a steady enough supply to bring on this malady.

Both the State Hospital for the Insane at Mendota and the Northern Hospital for the Insane have just completed surveys of their patients and both find that alcohol remains an important factor as a cause for insanity in spite of prohibition.

The records of both hospitals show that during the last twelve years cases of alcoholic insanity have averaged around ten per cent of all the patients admitted at the institutions.

"The number of alcoholics admitted has again almost reached that of the pre-prohibition days, as the statistical tables of causes will indicate," Dr. Sherman, in his official report, declares. "Of these cases considerably less than one-half show any psychosis and cases of delirium tremens are extremely rare, probably owing to the fact that not many can procure a constant supply of alcohol for a sufficient length of time to produce the characteristic symptoms of this disease.

"Most admissions showing a psychosis are cases of alcoholic hallucinosis, which usually clears up within a day or two after admission or not infrequently even before they reach the hospital.

"A small number manifest marked mental deterioration from which they never recover. Others suffer from acute alcoholic poisoning, which may result fatally within a few days or, if they recover, there often remains marked dulling of the higher intellectual faculties. The greater number of admissions are cases of simple alcoholic intoxication without psychosis, in other words, plain drunks, the repeaters of the police courts."

* * *

Uncle Sam's rural mail service cost the government last year $104,116,609.13, which was an increase over the previous year of $1,171,723.78, post office department figures show, according to information received at Madison. There were 45,318 routes covering 1,249,978 miles in operation at the close of the year.

Wisconsin has 1,751 routes extending over 46,805 miles. The first rural route established in Wisconsin was November 16, 1896, and extended fifty-six miles.

* * *

The Department of Public Instruction holds that the statute requires the school board to pay the teacher at least $75 per month. This is the minimum salary. A school district paying less forfeits its right to share in the school apportionment. It further holds that an Indian may be engaged as a public school teacher if possessing the necessary academic training and legal qualifications.

* * *

A painting of the late Gov. E. L. Philipp may soon join the portrait gallery of former state executives in the state capitol. A painting of the former governor was offered to the state years ago but the legislature got into a wrangle over the price the artist wanted for his work and members of the Philipp family took the painting. This portrait is now being offered to the state by members of the family as a gift to the state. Assemblyman John Gamper, Medford, fathered a joint resolution in the assembly to accept the portrait.

* * *

If legislators don't want women around them while engaged in their official duties there is nothing in the constitution or the equal rights act to force female employes on them. This in effect was the decision of Judge A. C. Hoppmann in circuit court here in ruling on a test case brought at the instigation of women's organizations who claimed the legislature did not have the right to bar

women employes. Only men are employed in the legislature.

With it definitely established that women cannot force members of their sex on the legislature as clerks and stenographers through the courts, a new drive will be started to wipe out the "male only" law at the next session of the legislature. Repeal of the law was attempted at this session but members of the assembly claimed that women employes about the legislature would constitute a moral hazard and killed the bill.

* * *

Wisconsin has about 80 public museums, according to a survey just made by the State Historical Society of Wisconsin. Of this number four are large museums housed in buildings of their own and receiving their entire or the greater part of their support from the cities whose educational needs they serve. About 20 others are located in colleges, state normal and other schools. About 50 small public museums are at present housed in public libraries, court houses, city halls, high schools and other public buildings. Among these are the historical and natural history collections at Baraboo, Kenosha, Waukesha, Whitewater, Portage, Fond du Lac, Darlington, Clintonville, New London and Racine.

* * *

Kidnapping for ransom may in the future carry a penalty as low as a five year sentence to state prison under the terms of the Schmiege bill, which has been signed by the governor. Prior to the enactment of this law, kidnapping for ransom was ranked the same as first degree murder and the judge had no option but to sentence such perpetrators to life imprisonment. The legislature believes that in cases where children are not injured in any way the judge should have the right to provide a shorter sentence. Under the Schmiege law a judge can sentence for this offense for terms from five years to life imprisonment, fitting the sentence to the nature of the individual crime.

* * *

That school officers have a perfect right to ask a lady applicant for a school whether she is in the habit of smoking cigarettes is the ruling of the State Department of Education in answer to an inquiry on this subject.

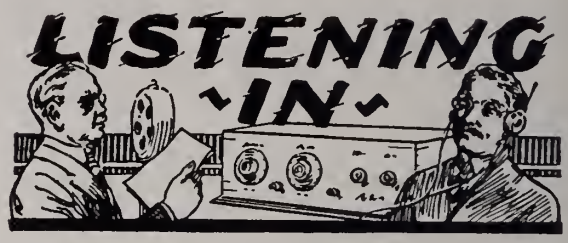
* * *

Streams that are navigable in spring but almost dry in summer cannot be fenced by the riparian owner, is the ruling of the attorney general's office.

"Title to the bed of a stream is in the riparian, but the state has an easement for navigation and its incidents," declares the opinion. "The people of the state may wade through the stream in search of fish or game and the owner would be destroying the interests of the state and its people in fencing across it. For this reason it would seem that this creek may not be fenced by a riparian."

* * *

More opinions have been asked of the attorney general by members of the legislature at this session than at any previous one. Practically every important measure before the legislature has been submitted to the attorney general for some opinion. The most important of these have been questions relating to the constitutionality of laws affecting home rule. Much legislation which previously would be legal is now held illegal as affecting cities under the home rule amendment.



NO CONSOLIDATION

Consolidation of departments of state government is a closed issue for at least another two years. Senator William A. Titus, Fond du Lac, who proposed to reduce the 73 state boards and commissions to 25, won unanimous approval of his measure in the senate, but the bill could muster only 10 votes in its support in the assembly and is dead for the present session. The same bill was before the 1925 session of the legislature, when it met even less endorsement and was killed in the house of its origin.

The legislature has had a number of other consolidation bills before it at this session but all have fallen by the wayside. Senator John C. Schumann, Watertown, had a plan to combine the department of agriculture with the department of markets and Senator H. E. Boldt, Sheboygan, introduced an interim committee bill to combine about a dozen departments under a new state board of public affairs of three members each, to receive a salary of $6,000 a year. Both failed.

The only important departmental change plan still alive in the legislature is a bill by Senator Herman Severson, Iola, which would abolish the board of public affairs, the state budget making body, and create a single office, budget director, to take its place.

INFORMATION APPRECIATED

There is increasing evidence that laymen here and there are attempting to profit on the basis of the great educational campaign now being conducted in the interest of periodic health examinations. Occasional organizations are being formed to sell the physicians' services to the public and in most instances the services of physicians are sought on false representations.

That the Society may have such information as will enable it properly to inform the public on these psuedo-service organizations, the members are asked to forward to the Secretary such information, letters, contracts, etc., as may come to their notice.

THIRD EDITION

Orders for copies of the leaflets on Periodic Health Examination published by the State Board of Health and reprinted at cost by the State Society continue to be in demand. This leaflet is now being printed in its third edition and has been approved for lay distribution by the Council.

THE INTERNE

Noting the letter on the status of the interne under the revised medical practice act as published in the July issue, the legislative council of the State Society suggests that the status of the interne is unchanged.

"I am inclined to think," states Mr. Fred M. Wylie, Madison, "that an interpretation of the present statute which first recognizes and mentions interneship would be that the statute legalized the interne to perform the same duties as he was performing at the time of the enactment of the new law. This would be a liberal construction, but I think might well be the conclusion from all the circumstances," The question arose under the new section requiring an interneship as a prerequisite to medical licensure in Wisconsin.

AN IMPORTANT POINT

When Governor Zimmerman signed the new law governing testimony of physicians he conceded to physicians an important point in the defense of malpractice cases. Under the old law only the physician sued might testify and even his testimony was limited in certain cases. The new law provides that the physician sued can testify without restriction and adds the most important point, that all other physicians dealing with the case can also testify without the patient's consent. This point was granted for the reason that a malpractice suit brings such information directly into the issue and the old law prohibiting it was in effect to deny to the physician sued what might be his only defense.

Preliminary Program For Eau Claire Annual Meeting Announced; Rooms Secured For 800 Membership Registration

"A program arranged with the basic thought of what will be of greatest value to the general practitioner."

With this statement the Program Committee for the Eighty-Sixth Annual Meeting announces the preliminary program in this Journal.

"We are prepared to house 800 members comfortably,"—Arthur Hedquist, Eau Claire Chamber of Commerce, Chairman of the Committee on Hotels.

"A full day's entertainment for every lady every day."

"The Golf Tournament is all arranged."

"There will be several surprises at the Smoker, —plenty of good fun."

"The Annual Dinner is going to be a real one."

"Alumni Luncheons will be a feature Thursday noon."

Such were the reports from Committee Chairman at Eau Claire on July 25th as result of which Chairmen Stang and Mitchell report that all is now in readiness for one of the largest meetings ever held by the State Medical Society of Wisconsin.

Declaring that reservation cards will be sent to every member during August and that no one need worry about suitable hotel accommodations if he makes reservations at that time, Mr. Hedquist set permanently at rest rumors and queries from other points in the state questioning facilities.

"Every hotel is turning over all its rooms for the days of the meeting. It will be hard on the traveling public but easy for the doctors. All they have to do is to make their reservations when they receive the card during the latter part of August. We will do the rest."

PRELIMINARY PROGRAM

The preliminary program for the scientific sessions follows:

WEDNESDAY

9:00 A. M.—Public Health

1. Dr. S. J. Crumbine, General Executive, American Child Health Association of New York City—"A United Front for Child Health."
2. Dr. W. S. Leathers, Vanderbilt University, Nashville, Tenn.—"The Health Officer, Medical Profession and the Laity."
3. Dr. R. S. Dinsmore, Cleveland Clinic, Cleveland, Ohio —"The Practical Aspects of the Goiter Problem."

Post Office

City Hall

Scene on Lake Hallie

1:30 P. M.—Medicine

1. Dr. Robert B. Preble, Professor of Medicine, U. of Ill., Chicago—"Mistakes in Medicine."
2. Dr. Elsworth S. Smith, Clin. Prof. of Medicine, U. of Mo., St. Louis—"Cardio-Vascular Renal Diseases."
3. Dr. Peter Bassoe, Assoc. Prof. of Medicine, U. of Ill., Chicago—"The Origin, Rise and Decline of the Neurasthenia Concept."
4. Dr. W. C. Alvarez, Rochester, Minn.—"The Physiology of the Gastro-Intestinal Tract."

8:00 P. M.—Public Meeting, High School Auditorium

1. Address of Welcome, Dr. Geo. W. Beebe, President Eau Claire and Associated Counties Medical Society.
2. Dr. A. S. Loevenhart, Professor of Pharmacology, University of Wis.—"Patent Medicines."
3. President's Address—Dr. A. W. Rogers, Oconomowoc, Wis., President of the State Medical Society of Wisconsin.

THURSDAY

8:30 A. M.—Surgery

Symposium: The Aspects of Surgery in Industry.

1. Dr. S. J. Seeger, Milwaukee—"Burns."
2. Mr. L. A. Tarrell, formerly of the Industrial Commission of Wisconsin—"Estimation of Disability."
3. Dr. H. E. Mock, Chicago—"Physiotherapy and Industrial Surgery."

2:00 P. M.—Surgery

1. Dr. Reginald Jackson, Madison—"Acute Surgical Abdomen, Diagnosis and Treatment."
2. Dr. Wm. F. Braasch, Rochester, Minn.—"Calculi in the Uro-Genital Tract."
3. Dr. Arnold Schwyzer, St. Paul, Minn.—"Principles of Surgery of the Gall Bladder."
4. Dr. C. J. Combs, Oshkosh, Wis.—"The Management of Common Fractures."

7:00 P. M.—Annual Dinner, Elks Club

(Speaker to be announced later.)

FRIDAY

8:30 A. M.—General Medicine and Surgery

Symposium: Methods of Examination in General Practice.

1. Orthopedics—Dr. F. J. Gaenslen, Milwaukee.
2. Neurology—Dr. Lewis J. Pollock, Ass't. Prof. of Neurology, Northwestern U., Chicago.
3. Urology—Dr. Ira Sisk, U. of Wis., Madison.
4. Obstetrics—Dr. Carl Henry Davis, Milwaukee.
5. Pediatrics—Dr. Isaac A. Abt, Professor of Pediatrics, Northwestern U., Chicago.

1:30 P. M.

1. "Treatment of Pernicious Anemia"—Dr. Geo. R. Minot, Ass't. Professor of Medicine, Harvard Medical School, and Dr. Wm. P. Murphy, Ass't. Professor of Medicine, Harvard Medical School, Boston.
2. (To be announced later.)

Elks Club, Where Smoker and Annual Dinner Will Be Held.

Putnam Drive

3. Joint meeting with the Wisconsin Oto-Laryngological Society. Two papers by Dr. Geo. F. Suker of Chicago and Dr. Gordon Harkness of Davenport, Iowa. Subjects to be announced later.

ENTERTAINMENT FOR LADIES

Complete arrangements have been made for an unusual program for the wives of visiting members and a special invitation is extended to them by the wives of the host society. As each member registers he will receive an envelope for his wife giving the complete program for the ladies. Preliminary plans now include a program for each day as follows:

Wednesday—noonday luncheons at the homes of the Eau Claire ladies. At 1:00 P. M. drive to Menomonie for bridge and golf tournaments. Late luncheon. Theatre party at Eau Claire.

Thursday—Automobile ride around Eau Claire and vicinity. Drive to Wissota Lake, Chippewa County, for luncheon and boat ride on the lake. Returning, drive through Irvine Park. Home in time for Annual Dinner.

Friday—Noon luncheon in Eau Claire. Afternoon bridge, entertainment and late luncheon at Country Club.

NEW GOLF RULES

"Plenty of prizes but only one to a person" is the new golf tournament rule according to Dr. G. E. Curtis, Chairman of the tournament play.

"In accordance with the usual custom," declared Dr. Curtis, "the two main prizes for the Tuesday tournament will be the President's and Secretary's cup. The former is for the low gross score and the latter for the low net score. Other prizes will be awarded the runner-ups and still more for the best choice scores on 9 of 18 holes, low gross and low net."

Dr. M. P. Andrews of Manitowoc now holds the President's Cup while Dr. J. H. Carroll of Milwaukee is possessor of the Secretary's Cup.

"While more complete announcements will be sent every member, we wish it understood," said Dr. Curtis, "that this will be a tournament play in

Rural Normal School

Gillette Rubber Company

every sense of the word. Players will go out according to schedule immediately after lunch; the morning may be used for becoming familiar with the course. Special games may be arranged for the following day."

HEALTH OFFICERS MEET

On Tuesday, the State Board of Health will conduct the Biennial Conference of State Health Officers commemorating the fiftieth anniversary of the founding of the State Board of Health as result of legislation fostered by the Sauk County Medical Society and the State Medical Society of Wisconsin. The program will be concluded Wednesday morning with a joint meeting of the Conference and the State Society.

The first meeting of the House of Delegates will be held on Tuesday evening at Hotel Eau Claire and subsequent sessions will be held at the Hotel and the Academy.

EXHIBIT RESERVATIONS

With but two exceptions, all exhibit booths for the session have been reserved. Reservations made follow:

Abbott Laboratories, North Chicago.

Board of Health of Wisconsin, Madison.

DeShell Laboratories, Chicago.

H. G. Fischer Co., Chicago and Milwaukee.

Hanovia Chemical & Manufacturing Co., Newark, N. J.

Horlick's Malted Milk Company, Racine.

E. H. Karrer Company, Milwaukee.

Kelley-Koett Mfg. Co., Inc., Covington, Ky.

Kremers-Urban Company, Milwaukee.

Medical Protective Company of Fort Wayne, Indiana.

Mellin's Food Company, Boston, Mass.

Victor Mueller Company, Chicago.

Pengelly X-Ray Company, Milwaukee and Minneapolis.

Physicians' and Hospitals' Supply Company, Minneapolis, Minn.

Pitman-Moore Company, Indianapolis, Indiana.

Roemer Drug Company, Milwaukee.

Saunders Publishing Company, Philadelphia, Penna.

E. R. Squibb & Sons, New York City.

Victor X-Ray Corporation, Milwaukee and Chicago.

University of Wisconsin, Medical Package Library Service.

New Insane Commitment Bill Before Governor; Physician's Testimony and Poor Relief Bills Signed

Passing both Senate and Assembly, the proposal of the State Medical Society to substitute a commission of physicians for a lay jury in trials to determine sanity and abolishing the old fee limitation of $4.00, is now in the hands of the Governor for his approval.

The bill as passed, 156-S., contains some revision of the statutes relating to insanity inquiries in county courts to simplify the procedure.

The main feature of the bill, however, is the elimination of the jury from insanity inquiries both upon the original hearing and upon retrial.

BULLETIN
Governor Zimmerman vetoed the insanity commitment bill as the Journal went to press.

Upon the original hearing the judge acts upon the report of the examining physicians, with the right in any person in interest to cross-examine and to offer evidence.

Upon a petition for reexamination three physicians examine and report, and the other procedure is the same as upon the original petition for commitment.

A further important feature of this bill is in provisions for carrying out of the plan of bill No. 550-S., suggested by the Board of Control, for a period of observation by the examining physicians, if necessary. One of these provisions repeals the present $4.00 limitation on the fee for examining physicians and provides that they shall be paid such compensation and expenses as are fixed by the judge.

During July the Governor approved of the following bills which were passed by both houses:

1. A bill bringing to date the old state narcotic law.
2. The bill authorizing compensation to physicians for emergency poor relief.
3. The Physicians' Testimony bill.

All three measures were the proposals of the State Medical Society in the form passed and signed.

NARCOTIC LAW BROADENED

The narcotic bill signed brings the state law into working harmony with the federal laws on this subject. Several drastic provisions affecting physicians were stricken from the old law by the bill and the only new important provision added is the proposal of the federal narcotic officials which provides that those dispensing the so-called exempt preparations containing narcotics must keep a registry as for the non-exempt preparations. This affects druggists in the main and its purpose is to detect the addicts who resort to purchasing large quantities of the exempt preparations in order to secure a dosage their system craves.

POOR RELIEF BILL SIGNED

Physicians throughout the state will benefit as result of the emergency poor relief bill. Under the old law a physician could not legally obtain compensation for such work unless previously authorized by the board concerned at a formal meeting. Under the new law the authorization of the town chairman, village president, mayor or chairman of the county board constitutes liability upon the body concerned for the expenses incurred. The bill does not so vitally effect those counties having a county-wide poor relief plan.

PHYSICIANS' TESTIMONY LAW REVISED

Under a substitute measure worked out in conference between the circuit judges of the state and the State Society, a new law has been enacted clarifying the old law on the subjct of privileged testimony of physicians. The new law grants some additional protection to physicians in malpractice suits, proposed by representatives of the judges, and makes clear the intent of the old law on this subject broadening its scope somewhat.

The new law provides that the privilege shall be absolute except in the following four instances:

(1) Trials for homicide. Here the public interest may require the physician's testimony to convict a felon, and the patient, it can be presumed, would have desired to have the testimony given.

(2) In lunacy inquiries. Here again an important public interest enters.

(3) Malpractice actions. Here the patient himself puts directly in issue his transactions with his physician.

(4) With the express consent of the patient, or in case of his death or disability, of his legal representative or other person authorized to sue for personal injury, or of the beneficiary of a policy on his life, health or physical condition. The new feature here is the insurance beneficiary, where the patient, it may be presumed, would have desired the testimony to be given.

The original bill would have destroyed the privilege that is now generally understood by the public, and have thrown open the most confidential relations between physician and patient for the benefit of private litigants, even when the patient had no interest in the litigation.

Two measures of interest to physicians were lost in the legislature during July. The first was a proposal by Senator Titus, Fond du Lac, that some 73 state boards be combined into less than twenty. The proposal would have consolidated all present examining boards placing their duties with the State Board of Health. This was opposed by the State Board of Examiners in Dentistry, Medicine and Chiropractic. The second bill provided a means for the state inspection and licensing of private sanitariums for the care of the insane. The

provisions of the bill were optional with the institutions. The Senate declared the expense of the measure was not justified by the benefits to be obtained.

The Nursing Problem

By ARTHUR W. ROGERS, M. D.,
Oconomowoc.

During the past few years there has been developing an increasing friction and misunderstanding between the nursing and medical professions. Likewise, the public at large has expressed grievances against the nursing profession.

Inasmuch as the doctor and nurse are so closely allied and interdependent in their professions, this situation is most unfortunate.

Where there is so much smoke there must be some fire, and it seems to us better to have this fire blaze up and burn out rather than to permit it to smoulder and widen this breach.

Why is there a "nursing problem," and what are the basic factors contributing to a possible misunderstanding?

This hue and cry about the private duty nurse is the direct outgrowth of a process of evolution which is taking place in the nursing profession. This profession has not kept abreast of progress in general and the medical profession in particular. It has realized but recently that something must be done to rehabilitate itself. Some of its efforts along this line have brought it into conflict with the medical profession and the public.

Those there are who claim that the nursing profession has become commercialized and that its "fees are outrageous." Indeed, sickness has become a very expensive affair, and when special nursing is necessary eight to sixteen dollars a day is prohibitive to most individuals. Let us pause to look at this part of the picture from the nurse's angle. Nursing is about the least attractive vocation a woman can take up. She has been under paid for years, and it is difficult to adjust to her increased charges, necessarily increased because of the increased cost of living to herself as well as to others. The nurse spends three years in preparation for service, she usually must maintain her quarters when employed, and her employment is very unreliable. We maintain that the fees charged by trained nurses are none too high, providing she renders the services to be expected of her.

Some states have statutes limiting the nurse's hours of duty, and this, of course, greatly increases the burden of expense, often necessitating the employment of a day and a night nurse. Have we, in the past, expected too much from the nurse? Possibly! Why should a woman require any less sleep and rest merely because she has taken the training of a nurse? We ask them to be all things to all people, to remain human though they cannot live like most human beings.

One of the most acute angles of this problem is the increasing shortage of nurses. This is quite readily explained, we believe. Today there are many lines of work open to women, instead of their being limited to housework, teaching, and nursing, as was the case some years ago. The demand for nurses has been greatly increased, not only from the public but because of the very great increase in hospitals throughout the country, calling them to executive positions. All first class training schools have raised their standards from one or more years of high school training to four years—some even requiring a university degree. The work and hours of the nurse are so undesirable compared to other lines that many have turned, or are planning to turn, to other means of occupation. In fact, a recent survey in New York State found that this exodus amounted to from thirty to fifty percent; then, too, the development of public health and industrial nursing has drawn off a large quota of women from the field of private nursing.

From the foregoing facts we believe that the unbiased observer must grant that the trained nurse in asking her present fees is barely making a living wage—at least, a careful survey of the subject proves such to be the case. The observer must further appreciate the fact that an acute situation exists and is certain to become worse unless some radical measures are resorted to.

Our study of this problem leads us to the conclusion that it presents three separate angles: the nurse, the medical profession, and the public.

How can these three angles be converged into a satisfactory and smoothly operating whole? In short, what is the solution of this problem?

The A. M. A., a number of state medical societies, and some local organizations are working

on this problem, but the most elaborate and comprehensive work has been undertaken by what is termed the "Committee on the Grading of Nursing Schools." This committee is composed of representatives from the National League of Nursing Education, the Natoinal Organization for Public Health Nursing, the American Nurses' Association, the A. M. A., the American College of Surgeons, the American Hospital Association, and the American Public Health Association.

With such an array of notables staging a thorough investigation, as their plan calls for, over a period of five years and at an expenditure of $200,000, we should expect much constructive work and a probable satisfactory solution for the entire problem; but five years is a long time, and what in the meantime?

In the larger centers of population the shortage of nurses and the inability to meet present nurses' fees, can be quite readily solved by a well-organized visiting nurses' association. Comparatively few sick people require the full time nurse, so that hourly nursing made at a reasonable charge will meet their requirements. This is working out very satisfactorily in Milwaukee and other cities. In a number of hospitals group nursing has been successful in meeting the same complaints. Above all, each city should have one reliable central nurses' registry, where physicians could promptly secure at any time during the twenty-four hours the type of nurse they required. This registry should be alike impartial to physician and nurse, and should supply not only trained nurses but reliable and competent practical nurses. In rural communities the problem is more complex, and is complicated by the tendency of the trained nurse to prefer large centers for her activities; and too, her unwillingness to go "outside." We find that some physicians in small communities have developed a small group of "footloose" women to do their work, and they get by their problems in this way.

Out of this welter of confusion, perplexities and various angles we are constrained to believe that we are being forced to the point where two groups of nurses must be provided by the training schools; one with high requirements of admission and a long and severe training, for special work, teaching, and executive positions, and another with lower requirements and at least one-half the time of training, their respective compensations to be arranged according to their training and competency. These practical nurses would at the same time serve to solve the problem of quantity and expense. There will always be people able and willing to employ the trained nurse. This plan would in no way lower the standards of the trained nurse, and we believe it would go far toward relieving an increasingly embarrassing situation.

Medical Service*

By C. A. HARPER, M. D.
State Health Officer of Wisconsin
Madison

In analyzing the term "medical service" it is interesting to note the rapid expansion of facilities placed at the disposal of the public and the medical profession to aid the individual as far as possible to a normal degree of health.

In the United States there are 6,778 hospitals and institutions with a total bed capacity of 845,494. We find that the cost per bed during the last ten years ranges from $3,000 to $4,500. If we accept the minimum cost per bed of $3,000 we find that there is a capital investment of $2,536,482,000. This excludes the investment in grounds, nurses' home, and many other incidentals. Probably about $5 a day is a reasonable bed maintenance. At such rate there is a daily expenditure for hospital beds in the United States of $4,227,470, or a yearly expenditure of $1,543,026,550.

It has been scheduled by one of the architectural magazines for the year 1927 that there will be spent more than $227,000,000 for new hospital construction in addition to repairs estimated in the neighborhood of $73,000,000 or a yearly expenditure for repairs and new hospitals of $300,000,000; an outlay for capital investment of $1,000,000 a day for each working day of the year. This provides for one hospital bed for each 138 individuals, the usual estimate being one bed for each 200 individuals.

Bringing the proposition to a state as a unit we find that in Wisconsin there is a total bed capacity of 24,329. Four thousand three hundred twenty-seven of these beds furnish accommodations in

* Presented before the Conference of Provincial and State Health Officers, Washington, May, 1927.

state and county institutions. One thousand two hundred sixty-six are federal beds, leaving 18,736 beds for general medical service, or one bed for every 118 individuals. Eliminating bed capacity of state and county institutions and those of the federal government there remains a bed capacity for every 144 individuals supported in part by municipal units, donations, or locally through private enterprises. It can be well said that these institutions are for the purpose of caring for individuals suffering from diseases or accidents, maternity cases excepted.

If we eliminate in Wisconsin the 1,266 federal beds we find on the basis of $3,000 per bed that the people of the state have invested in hospital facilities $69,189,000; while the federal government has invested in Wisconsin $3,798,000. If we take the 23,065 hospital beds in this state at $5 per day there is a daily expenditure for maintenance of $115,325 or a total maintenance for a year of $42,093,625.

These are some of the facilities now created in part for "medical service." It speaks well indeed for the citizenship of this country that responds so freely to meet the needs of suffering humanity. Unfortunately, however, it is the crippled ship that gets the big headlines rather than the barnacles that are the incapacitating agency.

As public health officials we are naturally interested in the harbor of relief, but more thoroughly interested in eliminating the agency that makes these harbors so fundamentally essential.

This brings us to the question then as to the amount of expenditures on the part of the people of the United States for "medical service" or the relief and cure of disease as compared with the expenditures on the part of the same citizenship in applying the agency of prevention. The figure of 100 to 1 is merely a suggestion by comparison.

Curative "medical service" extends since the time of man. The scientific prevention is relatively of recent origin. The accomplishments of disease prevention as we all know, have been most remarkable. The practical elimination of certain types of communicable disease with the most marked reduction in many other forms of communicable disease is no longer a subject of controversy. Should there by applied facilities for prevention the same as is now applied for relief and cure many men would rightfully have a ninety-nine year lease on life.

Man, however, is a sensitive individual. When his kindly family physician suggests that probably a mole or little tumor should be removed as a matter of precausion, you will generally find this individual clenching one fist at the doctor and holding the other one on his pocketbook, emphatically resenting the kindly and yet most scientific advice that could be given. Again we may find this same individual in later years taking a bed in one of the hospitals endeavoring to convalesce, so to speak, from a serious major operation because the family physician's advice was not followed when the procedure of extending relief would have been simple and safe. Now, however, in critical illness the physician's advice is followed, the pocketbook opens to the magnetic steel of the surgeon with the hope that after recovery, if recovery is made, there will be a few years' extension of existence.

This picture is not uncommon, but is an everyday occurrence. In fact, every medical man is so familiar with the story that no further elaboration is necessary.

When, then, will the human family begin to pay attention to the great advances made in the field of preventive medicine and appreciate that the normal state of health is a valuable asset, not only to the individual himself, but to his family, the community and the government as a whole.

PROBLEM OF EDUCATION

Public health officials are generally agreed that the remarkable results obtained following the crusade against certain communicable diseases can almost be paralleled by the proper co-operation of the citizenship toward diseases, constitutional in type. This last type can be handled properly only through the periodical examination of the apparently healthy individual. The question, then, is how to convince the man apparently healthy that an annual health examination by a capable physician may not only forestall the possibilities of some disease setting in, but may, to the surprise of the individual, detect certain forms of incipient disease, which if taken early and properly handled may be checked in its incipiency.

It may be stated that public health activities in the past have been, so to speak, collective in type, applied to governmental units. When public health officials begin to deal with non-communicable diseases that efforts are being directed to the individual rather than the community. We do not believe that this criticism is well founded. The ob-

ject is to protect the human family from all delibitating agents. If we educate a man to the importance and value of a periodic physical examination when in apparent health we educate a factor in a community that will tend to spread the propaganda better than by any other means.

Frequently then we are reaching the community through a general educational program, directly and indirectly, by dealing with individuals. Any education along the lines of health to the individual or a community is certainly a public health problem.

Periodic health examinations wherever systematically put into effect have proven their value beyond doubt. It is a tremendous factor in life extension.

Accepting the principle, how are we to proceed? No general satisfactory plan apparently has been worked out. It is a medical problem as well as a public health measure. It cannot, in our judgment, be satisfactorily handled by either agency alone. Therefore, it requires painstaking, scientific co-operation of all. It also requires much educational work.

The public criticism occasionally made that such a procedure is for the financial interest of the medical profession is wholly unfounded. The cost of a week's illness in a hospital with nurse and attending physician would pay the expense of an annual physical examination for many years, besides saving much time and frequently the prevention of a serious illness. The medical profession has been taught to diagnose disease and apply the methods of treatment. It is now preparing itself, in many localities at least, to properly instruct the apparently healthy also.

The difficulty frequently confronted by the individual physician with his colleagues as well as the public is often a detering factor. These objections are not so tenable when made the public health problem.

WISCONSIN'S PLAN

The following plan is being tried in one state. The state board of health is issuing a four-page leaflet stating the advantages of a health examination. This pamphlet is distributed very generally, and is readily accessible to all. It treats the problem as a health problem.

Each county medical society within the last six months has devoted one entire meeting to practical demonstrations and discussions of a physical examination of the apparently healthy. These demonstrations were instructional in type for the purpose of familiarizing the medical profession as a whole as to the method of procedure for a uniform type of physical examination.

The secretary of the state medical society, a layman, prints these public health bulletins in large numbers. Physicians may obtain them at cost plus postage necessary for mailing. The physicians extend to the secretary of the medical society a list of individuals who may be considered in the main a part of his clientele. The bulletin is then mailed to the individual whose name and address has been given. No physician's name appears on the envelope or on the bulletin. This leaves the recipient entirely free as to his choice of a physician to make this physical examination. It can not be considered as soliciting business on the part of any one medical man. If the individual has changed his medical adviser, the new medical adviser can not take exception to literature of this character when it does not carry with it the name of any physician. This shows a marked co-operation between the medical profession and the public health officials for the good of the public as a whole.

Whether the plan suggested herein will be as efficient as others that may be tried, we are not prepared to state. Time will demonstrate its merits. It is to be hoped that other methods on the part of the public health officials will be put into effect so that in the near future the best general uniform method of procedure can be formulated.

To life insurance companies such procedure is put upon a business basis and has been found 100 per cent profitable. If it is profitable from a financial standpoint, it should be profitable from a health standpoint. It remains to be seen what the best policy of procedure may be. We recommend the principle as a wise one.

PAIN

M. J. Hubeny, Chicago (*Journal A. M. A.*, July 23, 1927), says that the experience of roentgenologists shows that the severity, persistence or total absence of pain are often at variance with the magnitude of the disease; also that many combinations or complications exist. Roentgen-ray diagnosis often assists in explaining the cause of pain because it reduces the intangible to the tangible. All roentgenologists have seen many cases in which pain or the absence of pain assisted in either proving or disproving a clinical diagnosis, which syndrome could be explained by a thorough roentgenologic examination.

THE JOURNAL BOOK SHELF

Examination of Children. By clinical and laboratory methods. By Abraham Levinson, M. D., Associate in Pediatrics, Northwestern University Medical School. Second edition, with 85 illustrations. Price, $3.50. C. V. Mosby Company, St. Louis, 1927.

Nineteenth Annual Conference of the American Association of Medical Milk Commissions and The Certified Milk Producers' Association of America, May 25-26, 1925, Chalfonte-Haddon Hall, Atlantic City, N. J.

Management of the Sick Infant. By Langley Porter, M. D., Prof. of Clinical Pediatrics, University of California Medical School, and William E. Carter, M. D., Instructor in Pediatrics, University of California Medical School, San Francisco. Third revised edition. Illustrated. Price, $8.50. C. V. Mosby Company, St. Louis, 1927.

Should We Be Vaccinated? A survey of the controversy in its historical and scientific aspects. By Bernhard J. Stern, Instructor of Sociology, Columbia University. Price, $1.50. Harper & Brothers, Publishers, New York and London, 1927.

Obstetrics for Nurses. By Joseph B. DeLee, M. D., Prof. of Obstetrics, Northwestern University Medical School, Chicago. Eighth edition, revised. Pages 635, with 266 illustrations. Cloth, $3.00, net. W. B. Saunders Company, Philadelphia and London, 1927.

A Manual of Gynecology. By John Osborn Polak, M. D., Prof. of Obstetrics and Gynecology, Long Island College Hospital; Prof. of Obstetrics in the Dartmouth Medical School. Third edition, thoroughly revised. Illustrated with 145 engravings and 12 colored plates. Price, $5.00. Lea & Febiger, Philadelphia, 1927.

Dental Materia Medica and Therapeutics. With Special Reference to the Rational Application of Remedial Measures to Dental Diseases. A textbook for students and practitioners. By Hermann Prinz, D. D. S., M. D., Prof. of Materia Medica and Therapeutics, The Thomas W. Evans Museum and Dental Institute School of Dentistry, University of Pennsylvania. Sixth edition, enlarged and revised according to the United States pharmacopeia, tenth decennial revision. Price, $6.00. C. V. Mosby Company, St. Louis, 1926.

Exodontia. A textbook of Exodontia, Oral Surgery and Anesthesia. By Leo Winter, D. D. S., Prof. of Oral Surgery, New York University College of Dentistry. With 329 illustrations. Price, $7.50. C. V. Mosby Company, St. Louis, 1927.

A Text Book of Medicine. By 130 American authors. Edited by Russell L. Cecil, M. D., assistant professor of Clinical Medicine, Cornell University, Medical School, New York. Octavo of 1,500 pages, illustrated. Cloth, $9.00 net. W. B. Saunders Company, Philadelphia and London.

Medical Clinics of North America. Vol. X, No. 5, Boston number, March, 1927. Octavo of 311 pages with 34 illustrations. Per clinic year, July, 1926, to May, 1927. Paper, $12.00; cloth, $16.00. W. B. Saunders Company, Philadelphia and London.

Diseases of the Digestive Organs. With special reference to their diagnosis and treatment. By Charles D. Aaron, M. D., Prof. of Gastro-Enterology and Dietetics in the Detroit College of Medicine and Surgery. Fourth edition, thoroughly revised. Illustrated with 174 engravings, 70 roentgenograms and 13 colored plates. Price, $11.00. Lea & Febiger, Philadelphia, 1927.

New and Nonofficial Remedies, 1927, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1927. Cloth. Price, postpaid, $1.50. Pp. 473 XLVII. Chicago. American Medical Association.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1926. With comments that have appeared in The Journal. Cloth. Price, $1.00. Pp. 73. Chicago: American Medical Association, 1927.

BOOKS RECEIVED FOR REVIEW

Overcoming Tuberculosis. An almanac of recovery. By Gerald B. Webb, M. D., former President, National Tuberculosis Association; President, Colorado School of Tuberculosis, Colorado Springs; and Charles T. Ryder, M. D., Colorado School of Tuberculosis, Colorado Springs. Third edition revised. Price, $2.00. Paul B. Hoeber, New York, 1927.

The Human Body in Pictures. By Jacob Sarnoff, M. D., Associate Surgeon, United Israel-Zion Hospital, Brooklyn. A visual text of Anatomy, Physiology and Embryology. Price, $2.00. Physicians & Surgeons Book Co., Brooklyn, N. Y.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared original articles. By leading members of the medical profession throughout the world. Vol. II, 37th series, 1927. J. B. Lippincott Company, Philadelphia and London.

Lippincott's Pocket Formulary. By George E. Rehberger, M. D., author of Lippincott's Quick Reference Book. This little pocket therapeutics has been prepared to provide the practitioner with a conveniently sized ready reference manual. Price, $3.50. J. B. Lippincott Company, Philadelphia.

American Illustrated Medical Dictionary. The terms used in medicine, surgery, biology, dentistry, pharmacy, chemistry, nursing, veterinary medicine, and kindred branches. Edited by W. A. Newman Dorland, M. D., member Committee on Nomenclature and Classification of Diseases of American Medical Association. Fourteenth edition, revised and enlarged. Octavo of 1388 pages, 319 illustrations. Flexible binding, plain $7.00 net; thumb index, $7.50 net. W. B. Saunders Company, Philadelphia and London, 1927.

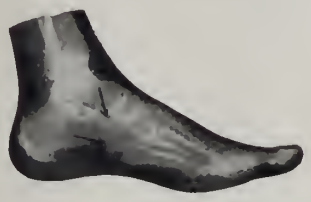
Medical Clinics of North America. Vol. X, No. 6, Heart number, May, 1927. Octavo of 211 pages with 101 illustrations and complete index to Vol. X. Per clinic year, July, 1926, to May, 1927. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

Collected Papers of the Mayo Clinic and the Mayo Foundation, 1926, Rochester, Minnesota. Octavo of 1329 pages, with 386 illustrations. Cloth, $13.00 net. W. B. Saunders Company, Philadelphia and London, 1927.

Text Book of Bacteriology. By William W. Ford, M. D., Professor of Bacteriology, School of Hygiene and Public Health; Lecturer on Hygiene, School of Medicine, Johns Hopkins University. Octavo of 1069 pages with 186 illustrations. Cloth, $8.50 net. W. B. Saunders Company, Philadelphia and London, 1927.

A Text Book of Pathology. By Alfred Stengel, M. D., Professor of Medicine, University of Pennsylvania, and Herbert Fox, M. D., Professor of Comparative Pathology, and Director of the Pepper Laboratory of Clinical Medicine, University of Pennsylvania. Eighth edition, reset.

DO NOT OVERLOOK THE FEET IN YOUR EXAMINATION



The symptoms of corns, callouses, bunions, burning, aches, pains, hammer toes, flat feet, and Morton's toe point to the falling of one or more of the arches of the feet. The x-ray picture above shows the cuboid bone dropped down along its inner border; and since this bone is the outer edge of the Posterior Transverse Arch, it proves that this, the main arch of the foot, has fallen.

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Kundert's Shoe Shop, Monroe
Nelson Shoe Store, Racine
Kahn Dry Goods Store, Racine
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Octavo of 1138 pages, with 552 text illustrations, many in colors, and 18 colored plates. Cloth, $10.00 net. W. B. Saunders Company, Philadelphia and London, 1927.

Tiger Trails in Southern Asia. By Richard L. Sutton, M. D., Fellow of the Royal Geographical Society and Prof. of Dermatology, University of Kansas. With 115 original illustrations. Price, $2.25. C. V. Mosby Company, St. Louis, 1926.

While few physicians can devote several months to a hobby, there are none who do not enjoy reading of the experiences of a brother practitioner who has had this good fortune. This volume of adventure and scientific study in Indo-China and India is as fascinating as a novel. The reviewer commends it to anyone who desires to forget his troubles.—J. G. C.

The New Medical Follies. By Morris Fishbein, M. D., Editor of the Journal of the American Medical Association and of Hygeia. An encyclopedia of cultism and quackery in the United States, with essays on the cult of beauty, the craze for reduction, rejuvenation, eclecticism, bread and dietary fads, physical therapy, and a forecast as to the physician of the future. Boni and Liveright, New York, 1927.

Fifteenth Annual Report. United Fruit Company, Medical Department, Boston, Mass.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 153 E. Wells Street, Milwaukee, Wisconsin. These new books will be loaned for an inspection period only.

Overcoming Tuberculosis. An almanac of recovery. By Gerald B. Webb, M. D., former President, National Tuberculosis Association; President, Colorado School of Tuberculosis, Colorado Springs; and Charles T. Ryder, M. D., Colorado School of Tuberculosis, Colorado Springs. Third edition revised. Price, $2.00. Paul B. Hoeber, New York, 1927.

A book deserving of a larger circulation than it is likely to get. It should prove an invaluable assistant to physicians who are conscientiously attempting the "home treatment of tuberculosis". The first half is devoted to "perfectly orthodox" but well expressed instruction of "what every tuberculosis patient should know". The latter half is in the form of an ingenious almanac arrangement in which the patient can keep his pulse, temperature, weight and diary notes. Each of these pages also contain two quotations or aphorisms designed to make him think right. The selection ranges from the classics (including the Bible) to contemporary tuberculosis authorities. I believe the average patient would profit more from ownership of a copy of this book than he would from a shot of tuberculin, an exposure to a quartz lamp, or a bottle of cod liver oil.—H. E. D.

City Health Administration. By Carl E. McCombs, M. D., National Institute of Public Administration and New York Bureau of Municipal Research. The Macmillan Company, New York, 1927.

In reading over the first few chapters of this book, one is apt to become prejudiced against it because the writer appears to be too favorable to the City Manager Plan of municipal government. This prejudice, however, is soon overcome when one sees how accurately and impartially all questions pertaining to public health are discussed in the subsequent chapters. No matter whether one agrees with all of the conclusions of the writer, it must be admitted that the author of this book obtained his information from the most up-to-date and reliable sources. There is very little health work of any value, which is being carried on by a modern Health Department, which has not been masterfully discussed by the author.

This book should be equally valuable to both the laymen and the professional health worker. It is written in such way that the non-professional health worker can understand it and it covers every health subject so thoroughly and so scientifically that even a health officer of long experience and training can gain valuable information and much inspiration. This book, if carefully read and studied by the general public as well as health workers, cannot help but exert a very beneficial influence upon the future health work.—J. P. K.

The Tired Child. By Max Scham, M. D., and Grete Scham, Ph. D. Price, $2.00. J. B. Lippincott Company, Philadelphia.

This is a volume written in simple language for parents and teachers, as well as physicians, which concerns itself with the results of fatigue in infancy and childhood, as well as its cause and prevention. It is a timely book, for the conditions of present day living have harmed and injured young children. There are many valuable suggestions to be found in this treatise and much of it will be of help to the physician in the handling of malnutrition cases and those children who are below par.

At the end of each chapter is a list of references for those who desire more information about the subject presented.

This is one of the few sensible and worth-while books on the subject of child guidance.—R. M. G.

Methods and Problems of Medical Education. Sixth series. Division of Medical Education, The Rockefeller Foundation, 61 Broadway, New York City, 1927.

This is the sixth series of publications dealing with problems in medical education put out by the Rockefeller Foundation. For those who have to do with the building and equipping of medical school libraries and laboratories these volumes should be of great help. Clinics of many countries are described with detailed drawings showing the arrangement of equipment.

The Foundation has given to the medical world some very valuable information in these volumes.—L. M. W.

How to Make the Periodic Health Examination. A manual of procedure. By Eugene Lyman Fisk, M. D., Medical Director, Life Extension Institute, and J. Ramser Crawford, M. D., Assistant Medical Director, Life Extension Institute. The Macmillan Company, New York, 1927.

Any well-written book that brings the subject of the Periodic Health Examination to the attention of the medical profession has a definite value. This volume is such a book. From a theoretical standpoint "How to Make the Periodic Health Examination" contains many valuable and

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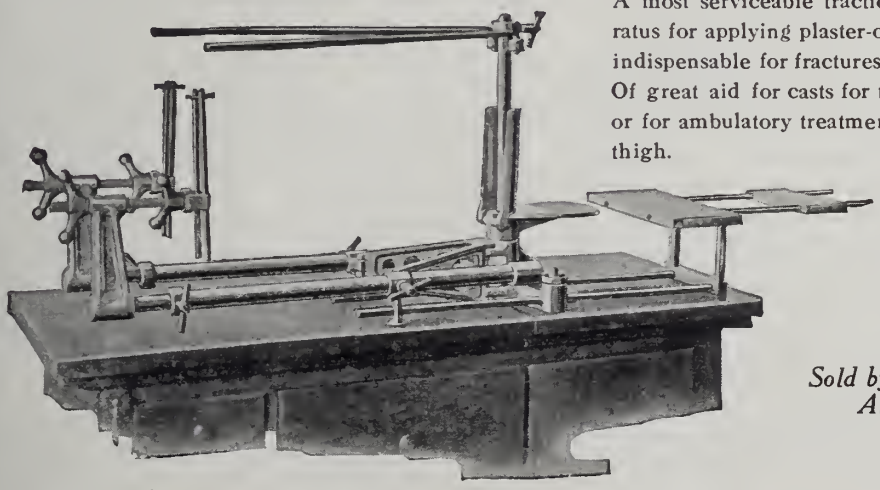

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worth-while suggestions, but from a practical angle, I believe the authors have missed the mark.

The examination of the individual is divided into seventeen sections; as "The Mouth," "The Nose, Throat and Ear," "The Eye," "The Circulatory System," etc., and every section is written by a specialist. The result is that while the book is of great assistance to the man specializing in Health Examinations, for the general practitioners who must do this work during the course of a busy day the examination is entirely too detailed.

If the Periodic Health Examination is ever going to be of value to the general public and serve the purpose for which intended, it must be placed within the reach of the general public. The reviewer does not believe that the examination as outlined, including the history, which contains more than 150 questions, the physical examination of sixteen regional examinations, the laboratory examination, and finally the suggestions and advice given can be made within two hours. The reviewer fully appreciates high ideals and high standards, but from years of practical experience he knows that such an examination as suggested by the authors cannot be made at a cost within the reach of Mr. and Mrs. General Public.

The Periodic Health Examination as outlined in this book is a luxury and will never become popular. If the production of automobiles had been limited to the manufacture of Pierce-Arrows and Packards, the automobile game would be twenty years behind its present stage. The small, reasonably priced, but good car, within reach of the butcher, the baker, and candle-stick maker has made transportation what it is today.—O. L.

Practical Lectures on the Specialties of Medicine and Surgery. Delivered under the auspices of The Medical Society of the County of Kings, Brooklyn, New York. Second series, 1924-1926. With 110 illustrations. Price, $7.00. Paul B. Hoeber, New York, 1927.

This volume of practical lectures sponsored by the Medical Society of the County of Kings, Brooklyn, New York, has many very interesting short articles. The reviewer can readily understand the interest that was taken in these lectures, and the collection of all into one volume available for the general medical profession is a real service for which the editors should be congratulated.

The subjects covered are numerous and the articles are so written that any medical man can read them with profit. The volume has a good index which enables one to find readily whatever subject one is looking for and the illustrations are very well done.—L. M. W.

Lectures on Internal Medicine. Delivered in the United States in 1926. By Knud Faber, M. D., Prof. of Internal Medicine, University of Copenhagen, Denmark. With 43 figures and charts. Price, $3.00. Paul B. Hoeber, New York, 1927.

These four lectures given by Dr. Knud Faber are very interesting. The first one on Achylia Gastrica presents a somewhat different viewpoint in regard to the disease, based upon careful histological examination and clinical findings. The second one on the Intestinal Origin of Pernicious Anemia seems to the writer to be decidedly less interesting. Dr. Faber argues for the intestinal origin but he leaves out entirely the work which has been done with the Bacillus aerogenes capsulatus and his arguments are not convincing. In his third lecture on Benign Glycosuria he takes up the question of blood sugar but brings out no new points. The last lecture is on the Historical Outline of Medical Therapy in which he traces in rather rapid fashion some of the high spots in the therapy of disease.

The volume containing these lectures is certainly worth while having in one's library. It represents the opinions of a clinician who is widely known in his own and other countries and whose viewpoint and training are somewhat different from that to which we are accustomed. The book is attractively printed and the illustrations are well done. —L. M. W.

THERAPEUTIC NOTES

New and Nonofficial Remedies

In addition to the articles enumerated previously, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

H. K. Mulford Co.

Antivenin (Nearctic Crotalidae)—Mulford.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

Neonal—*N*-Butylethylbarbituric acid.—Neonal differs from barbital (diethylbarbituric acid) in that one of the ethyl groups of the former is replaced by a normal butyl group. The actions and uses of neonal are essentially similar to those of barbital, but it is about three times as active as the latter; hence it is used in correspondingly smaller doses. It is claimed that it exerts a sedative action to an exceptional degree, and that it is useful therefore in high nervous tension, neuroses and other conditions in which a sedative is required. Neonal is supplied in powder and in 0.1 Gm. tablets. Abbott Laboratories, North Chicago, Ill. (Jour. A. M. A., June 4, 1927, p. 1802.)

Pollen Extracts—Cutter.—These are now marketed in capillary tubes and in packages consisting of three vials representing graduated concentrations. In addition to the products listed in New and Nonofficial Remedies, 1927, p. 34, the following have been accepted: Alkali Weed Pollen Extract—Cutter; All Scale Pollen Extract—Cutter; Box Elder Pollen Extract—Cutter; Burning Bush Pollen Extract—Cutter; Corn Pollen Extract—Cutter; Foxtail Pollen Extract—Cutter; Mountain Cedar Pollen Extract—Cutter; Tumbleweed Pollen Extract—Cutter; Western Water Hemp Pollen Extract—Cutter. Cutter Laboratory, Berkeley, Calif.

Pollen Extracts (Glycero-Saline)—Mulford.—Liquids obtained by extracting the dried pollen of plants with a liquid consisting of 66⅔ per cent of glycerin and 33⅓ per cent of saturated sodium chloride solution. For a discussion of the actions and uses see Allergic Protein Preparations (New and Nonofficial Remedies, 1927, p. 23). Pollen extracts (glycero-saline)—Mulford are marketed in bulk treatment packages and in treatment sets consisting of: First series (doses 1 to 5, inclusive); second series (doses 6 to 10, inclusive); third series (doses 11 to 15, inclusive); complete series (doses 1 to 15, in-

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The X-Ray in Children*

By WILLIAM G. ALEXANDER, M. D.
Evanston, Illinois

This paper is a result of observations based upon the co-operative experiences of four pediatricians and myself in Evanston, Illinois, and is intended to be clinical as well as definitely technical. From the many subjects that might be included under the above title I am going to limit myself to four:

1. The thymus gland.
2. Congenital hypertrophic pyloric stenosis.
3. Pertussis.
4. Pneumonia vs. acute abdominal lesions.

At the beginning of the discussion I wish to emphasize most definitely the importance of two things—the alertness on the part of the physician in suspecting pathological conditions, and, secondly, a close co-operation between the physician and the roentgenologist. The latter finds many pathological conditions that were unsuspected and come to light during examinations for other purposes—e. g., an enlarged thymus seen when the film is made for a fractured clavicle.

THE THYMUS GLAND

A survey of the Benjamin Clinic at Cincinnati, as reported by Friedlander (61), showed that by routine examination of the babies brought to them 8% showed thymic enlargement above the normal. Any pathological condition involving 8% of the population under one year would seem to warrant rather serious and disturbing contemplation, but the usual attitude of mind has been in the past to consider the thymus as an organ related only to fetal life and one to be forgotten after birth, except to know that babies sometimes die suddenly when at autopsy only an enlarged thymus gland was found to account for it. I am sure that many a person has been tried for murder of an infant in which the death was due to a lurking thymus gland. The attitude has been that an enlarged thymus was an accident in the child's life and that if it was severe enough, the child died, and that was all there was to it. This attitude has been a marked detriment to childhood and a severe strain on the parents, and especially on the surgeon who has been called upon to operate upon a child who died suddenly on the table, sometimes before the knife had touched the patient (90),—hence the value of the investigation that began a few years ago as to the method of diagnosing the presence of an enlarged thymus gland and measures for its treatment. The x-ray offers a solution for both of these.

Any study of the diagnosis and treatment of the thymus gland must begin with a review of the embryology and pathology of that organ. I shall try not to take too much of your time in a detailed study. Suffice it to say that the thymus originates from the third and part of the fourth visceral pouches by long cylindrical processes. The point of origin is very near that of the thyroids and parathyroids, and thymic tissue is often found in those glands, and, conversely, often thyroid and parathyroid tissue may be found in the thymus.

By increased growth these cylindrical masses pass downward into the chest, and, meeting across the midline fuse to make a single organ. In later fetal life they may be very low in the chest, with cord-like processes attached to the thyroid gland acting like suspensory ligaments on each side. These relations will be a little clearer when we look at some slides later that are reproductions from Shaefer's Histology (162).

Coplin (37) has divided the glands into four types—unilobar, bilobar, tri-lobar and conglomerate. Each group is again divided into cervical, cervico-thoracic and thoracic. These facts have a very distinct bearing upon the diagnosis, symptoms and treatment.

Like the thyroid, the thymus is ductless. It is well developed in late fetal life and in the newborn, and reaches its greatest development at two to eight years of age; then begins to reduce in size and is changed to adipose tissue.

It is about 5 cm. in length, 1.6 cm. thick and 3.5 cm. broad, weighing about 15 grams—anything

*Presented before State Medical Society of Wisconsin, Madison, September, 1926.

PLATE 1

Fig. 1. Origin of thymus and thyroid glands (Prenant); 1, 2, 3, 4, visceral pouches; *tm, tl*, thyroid sprouts; *th*, thymus; *g1, g2*, thymus.

Fig. 2. Section of a secondary lobule of the thymus (Schaefer); *c*, cortex divided into nodules by trabeculae, *tr; b, b*, blood vessels.

Fig. 3. Dissection to show relations of thymus to the adjacent organs (Barker); *T*, thyroid; *Ty*, thymus; *L*, lungs; *H*, heart.

Fig. 4. A dissection to show another type of thymus.

Fig. 5. Thymus of a child at 2 years (Noback).

Fig. 6. Various forms of thymus in new-born (Noback). None had breathed.

Figs. 7 and 8. Autopsy material (Noback).

over 25 grams being abnormal. Usually it lies in the upper thorax over the great blood-vessels molded about the trachea and lower down over the pericardium, with grooves for the great blood-vessels.

Its function is as yet unknown, although it seems to be associated with body growth, and yet its removal does not seem to retard the development, possibly due to the fact that distant and unremoved thymus tissue takes up the load (Park and McClure (138.)

Very important changes take place in the shape of the thymus at the beginning of respiration, as the lungs press laterally on the gland, as it lies between them, and a change from a broad, flat organ to a narrower and thicker one takes place. If too thick it will encroach upon the other organs and produce pressure symptoms. (Noback—137).

PATHOLOGY

This naturally divides itself into five topics:

1. The pathology due to varying position of the gland.
2. The varying shapes of the gland.
3. The tumors of the gland.
4. Simple hyperplasia of the gland.
5. The subinvolution results seen after infections of various types have lowered the vitality of the patients.

As we have already mentioned, the gland may be found from just below the thyroid at a location enveloping the upper part of the heart. The opening at the upper end of the chest through which the vessels, trachea and aesophagus pass to reach the head is less than an inch in the infant, so if the gland lies in that location very definite pathology may occur.

Again we may divide the gland forms into two types—flat and broad, narrow and thick. When the former is present the x-ray shadow is very broad, and yet the symptoms may be slight, while a thick, narrow type may not show much shadow by x-ray and yet definite and severe symptoms be present. A child may have a thymic death and yet at autopsy show a very large thymus gland and have an x-ray film that does not show much, if any, enlargement of the gland because the enlargement was in the anterior-posterior direction. Possibly lateral views as suggested by Herrick (90) are of value, although they are not always satisfactory.

General hyperplasia may be a part of a general lymphatic enlargement that occurs in leukemia, pseudo-leukemia, and the "status lymphaticus" that is so much dreaded. This hyperplastic gland is very vascular. The gland is found to be the seat of multiple hemorrhages in many of the autopsies, especially in deaths from difficult labor and from violent crying of the child. In many of these cases cyanosis is associated with violent crying, evidently due to pressure on the veins and trachea. There is a real danger in this connection with the radiography and treatment of a baby that shows a definite fear or resentment at the confinement necessary to such procedure, and I feel that great care to keep the child as quiet as possible should be used. Let the babe remain in the hands of the parent while the machinery is being adjusted, and then keep the child under the tube as short a time as possible. I do not believe definite restraint should be used. Our method of handling the babe is to allow him the use of his arms and legs, and even a bottle feeding during the treatment. The operator is protected by a screen with lead glass window that rests on the table.

Occasionally older children die from what proves to be thymic enlargement. These cases show a history of being fairly normal at birth, but are subject to many of the children's diseases. They seem to develop a lowered vitality and the thymus gland seems to enlarge and produce typical symptoms long after the usual period of danger.

The thymus is the favorite site of origin of tumor of the mediastinal type. The best work, I think, on tumors of the thymus has been done by James Ewing, of New York. In addition to the chapter on thymic tumors in his classic book on tumors, a less detailed report appeared in S. G. O. in April, 1916 (53).

SYMPTOMATOLOGY

We must again refer to the anatomy and the anatomical relation of the gland to the other structures to understand the symptoms. The gland may press upon the trachea even to the extent of reducing the antero-posterior diameter and hence would give rise to difficulty in respiration and secondarily in nursing, as seen by strangling at the time of nursing. There may also be a peculiar stridor—a crowing respiration in both phases, due to the organic obstruction.

Again, the great vessels in the neighborhood may be pressed upon, as well as some of the more important nerve trunks, thus secondarily causing difficult respiration and circulation, hence causing

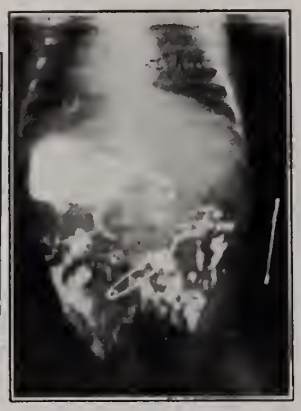

Fig. 9. Congenital Hyper. Pyloric Stenosis. Baby C., 15 minutes.
Fig. 10. Baby C., 2 hours. Diagnosis: Partial stenosis, recovery under cereal.

cyanosis on crying, convulsions, asthma, and general respiration infections.

Referring again to the shape of the gland, if the antero-posterior be the greater one, more effect will be produced than if it be broad and sheet-like and unable to produce much pressure in this direction,—hence also the broad shadow on the film and mild or absent symptoms with the child.

Whenever a new-born or young babe shows difficulties in breathing, is subject to habits of "holding the breath," especially if accompanied by cyanosis or convulsions, has symptoms that resemble croup or the presence of a foreign body, let us be certain to take into consideration the presence of a hyperplastic thymus and rule it in or out by an x-ray film. Percussion of the region may give us a clue, but the x-ray film is far more reliable.

There is considered by some a definite thymic asthma and it is interesting to note in this connection that Svehla (179) has shown that when large doses of a watery extract of the thymus are injected into dogs death takes place, with marked dyspnoea.

The occurrence of sudden death without sufficient cause must always lead to a consideration of the thymus as a cause.

The symptoms that are most suggestive may be summed up as follows:

1. Marked predisposition to catarrhal colds.
2. Presence of early anemia.
3. General low resistance.
4. Poor circulation, especially with cyanosis.
5. Chronic stridor on both inspiration and expiration.
6. Difficulty in nursing because of pressure.
7. Recurrent asthma.
8. Attacks of choking, with cough.
9. Attacks simulating foreign body in larynx or trachea.

DIAGNOSIS

The methods of diagnosis have already been referred to, but it seems that a consideration in more detail is essential.

1. Percussion is very inaccurate and should be confirmed by x-ray, if possible.
2. The x-ray film is diagnostic in probably 90 per cent of the cases.

Gerstenberger (69) emphasizes the fact that the shadow of the thymus varies considerably, depending upon whether it be taken at inspiration or expiration—the shadow being larger on deep inspiration—and recommends that the film be always taken at the end of inspiration—the patient being on the back with the chin under no extension. One will very quickly realize how difficult it is to obtain films at any definite part of the respiratory cycle when the child is at all active, as he usually is, and my own feeling is that more than one film be taken, with the hope of an average being the best that one can do. The fluoroscope will aid a great deal in determining the presence of the tumor. The most important point to be determined is whether the thymus is *enlarged* and not the exact diameter. It is best, of course, to always use the same position and distance from the tube. Make the exposure as rapidly as possible—50 ma. 5″ gap and 1/10 sec. at 30″ is sufficient. The films may not be show films, for the babe is usually crying and there may be some haziness in the lung shadows.

The interpretation of the film is not difficult and

Fig. 11. Baby F., 5 minutes after feeding.
Fig. 12. Baby F., 2½ hours. Diagnosis: Functional spasm, no organic obstruction.

Fig. 13. Baby W., 5 minutes.
Fig. 14. Baby W., 3 hours. Diagnosis; No obstruction.

yet care should be made to rule out other shadows than the thymus.

Clinically the diagnosis must be made between thymus enlargement and croup, foreign body in the trachea, intra-thoracic tumors, etc., but the most accurate method of doing this is by x-ray.

An interesting case is reported by Herrick, of Ottumwa, Iowa (90), who had a patient who was thought to have swallowed a safety pin. X-rays were taken to locate the foreign body and none was found. An enlarged thymus was seen and an operation refused, but in spite of this the symptoms were so suggestive of foreign body in the larynx that a tracheotomy was decided upon by other surgeons. At the first stroke of the scalpel the baby became cyanotic and died. Autopsy showed a very large thymus reaching from above the sternum down to and covering fully one-third of the pericardial sac.

TREATMENT

The older method of treatment was surgical, but in the nature of things that treatment has a very high risk and has practically been abandoned for the use of x-ray and radium.

The question of x-ray vs. radium immediately arises. It seems to me that either will do the work equally well, but the radium is not always available, while the x-ray machine is more general. The radium can be used in frightened children more readily than x-ray.

Radium has been much used by a limited number of men with the technique as described by Hubelein (95), cross-firing with 100 mg. radium element, with 3/10 cm. silver filter, at ½ inch skin tube distance, through 4 portals for 2 hours at each portal—800 mg. hours in all.

The best method for the use of the x-ray is one portal of exposure—using 5 ma., 7″ gap, 14″ distance, 3—5 minutes time—with 2 mm. aluminum and one of leather. This treatment is repeated every 10 days for 3 to 4 treatments. The area exposed may include the thyroid, although it is not involved.

It must be remembered that we are not clear yet as to the real function of the thymus, and so it would probably not be the best policy to use enough x-ray to carry the involution too far—to a point that would possibly affect the growth of the child. It is true that the experiments of Parke and McClure (138) seem to show that there seems to be no bad after-effect from surgical removal of the gland, but the treatment is rather symptomatic after all.

The statistics of this paper are based upon 108 babies sent to me because of some unusual symptoms suggesting thymic enlargement; 83 of these proved to have over-sized thymus glands. Sixty-nine of these were considered of sufficient size and symptomatology to receive treatment and were subjected to the x-ray in the dosage just mentioned. Absolute cure resulted in all but two cases. Of these two there remained a peculiar crowing respiration at times of excitement or on crying. I feel that there may have been some semi-permanent change in the contour of the trachea or larynx that may gradually reduce in time but could not resume the normal in the time under observation. Of the 83 cases 12 showed unilateral enlargement on the right side, 5 on the left, and the remaining 66 showed both lobes larger than normal. Of the remaining 14 cases some seemed to need no treatment, or in a few the interest of the parents could not be raised to the point of having the children treated. In some, definite reduction in

Fig. 15. Baby L., 5 minutes.
Fig. 16. Baby L., 4½ hours. Diagnosis: Definite pyloric stenosis, operative type. Rammstedt operation done with recovery.

the thymic shadow was seen in 4 weeks. In many cases the shadow did not seem to reduce so much in size, but the symptoms all disappeared, and I believe *this* is the criterion by which to judge results.

This is relatively a small number of cases on which to make any deductions, but results are in agreement with many other reports and so may be considered as of value in connection with the other statistics.

The points I wish to bring out are:

1. The condition of thymic hyperplasia is very common, but undiagnosed.
2. The condition is not difficult to diagnose, as a rule.
3. That there are many untoward effects to the patient other than the condition of possible sudden death.
4. That the treatment by x-ray and radium is very brilliant.
5. That the danger from this method of treatment is absolutely nil.
6. That surgery can be used, but that the dangers are great, both from the shock and the inherent danger of a status lymphaticus being present.

PLYORIC STENOSIS

The following suggestions are based upon some work reported in 1922 by Dr. Louis Sauer and the writer (47) on the emptying time of the normal stomach in babies of 1 year or less, using a thick-cereal feeding. This method of feeding has produced favorable results in many cases of partial pyloric stenosis, and the two questions to be answered in such children are, first, what is the degree of stenosis present and how does the emptying time of the stomach correspond to the time as determined in the normal child, using a feeding in which some barium has been incorporated, and, second, what progress is being made by medical efforts to relieve the stenosis, and shall operation be performed?

We have found rather reliable results available in our efforts to answer these two questions. Our method is to feed the baby after an interval of about 3 hours following any food, and watch the stomach's reception of the food. The barium is given, preferably in mother's milk, from a bottle with a wide opening in the nipple. By turning the baby on its right side the peristaltic waves that are so characteristic of pyloric stenosis in the adult, as well as the child, may be seen.

A film is taken about 5 to 10 minutes after the food (4—5 oz.) is taken, followed by films every 30 minutes for 4½—5 hours, the normal emptying time of a stomach on such food being 3½ hours. Strauss says that if at the end of 4 hours 80% of the barium has passed the pylorus no operation is needed. In ten years of his experience with 324 cases—100 have been regarded as medical, and so treated. This statement is possibly a little dogmatic, but it gives a general idea that may be used in making up a general decision about the baby when its general nutrition and other factors are also used.

I will show later series of films taken in this manner of babies—one requiring operation, the others making a perfect recovery on continued thick cereal feedings.

My purpose in this paper is not to discuss the pros and cons of the question whether congenital hypertrophic pyloric stenosis is medical or surgical. It is to point out that the question of such a condition being present and to what degree it has progressed can very definitely be determined, with no harm to the baby, by x-ray examination. Our own experience has been that a large percentage of these respond to medical care.

PERTUSSIS

We are now on very debatable ground, and I assure you I am not going to give you the last word on the subject in my paper. There are so many conditions to be brought under consideration and such variable statistics on this subject that even the Roentgenologists are somewhat divided.

However, I believe all will agree that there seems to be some very good ground for considering that children treated in the second and third weeks of the disease do show definite results. I think one must remember that x-ray as a therapeutic agent must follow the same laws as any other therapeutic agent and show varying results with various patients, due in part, at least, to the idiocyncrasies of the patient to the remedy. Some people are much more susceptible to x-ray in treatment of carcinoma than others—why not then in pertussis? We must also remember that pertussis is a very variable disease in its normal course, depending upon the epidemic, the child, the season and a number of other factors. But to one who has passed through 25 years of observation of these illnesses and the results of other treatments, this treatment seems to offer better results than any other one method if given in the second

Fig. 17. Baby Mc., 5 minutes.
Fig. 18. Baby Mc., 2 hours. Diagnosis: Partial obstruction, organic. Recovery.

and third weeks of the disease. The results are not so satisfactory in the later weeks, although one often sees the irritative after-cough cleared up as if by magic by a series of treatments. This may also be seen in post-influenzal coughs.

My deductions are based upon about fifty children treated during the past two years, and I feel that very definite results are obtainable in 80% of the cases—not a bad remedy. When one has seen the time that there was a mortality of 50% in babies under 3 months he is greatly relieved when this method seems to reduce the mortality to at most 10% or lower. In our own cases no child has died from the disease, but the number is too small from which to establish a mortality table. But the reduction of the vomiting, the less irritative cough and better rest to both child and parent that follow the raying of the chest form a very encouraging picture.

Our method of exposure of the whole chest, including the thymus, with partial protection to the thyroid, is about 24 ma. minutes on alternate days for 3 days, exposing the front of the chest twice and the back once with 1 mm. aluminum protection.

I believe the reduction in irritability of the bronchial glands is the cause of the results. I am conservative in my feelings, but I am happy to use any remedy that gives 80% results suffering from any other illness.

Other reports are:

Leonard & Bowditch, J. A. M. A., 1924 (15).
- 400 patients—relief of symptoms in 75%.
- 200 untreated cases.
  - 3 treatments in 3 days.

Struthers, Canad. Med. Assoc. J., 1924 (22).
- 48 cases—1 large treat.
  - 7 cases—promptly cured (14%).
  - 20 cases—relief (45%).
  - 18 cases—no relief (40%).
  - Not enough treatment.

Herman & Bell—Arch. Ped., 1924 (9).
- 300 cases by med. treat. no x-ray. 25% def. results.

L. Smith et al. J. A. M. A., 1925 (20).
- 850 cases—Treat. 36 ma. minutes.
- 80% have shown definite improvement in number and severity of paroxysms.

Hess (11) reports:

43% definite improvement.	Summer
32% definite but less.	and
25% no change.	Fall

Faber and Struble (7). J. A. M. A., 1925, claim in a series of 44 cases no improvement of the x-rayed cases over those treated by antipyrin—I think the areas treated were too small.

On the whole the reports are much more favorable to x-ray than any other one form of treatment.

PNEUMONIA

The diagnosis of pneumonia in children and differentiation from abdominal condition is one that cannot be emphasized too much. I would not limit it to children, but would recommend it in questionable cases in adults also, but as this paper is dealing with children I shall confine myself to that phase.

Appendicitis works quickly in children and one must use methods that will give a quick and accurate diagnosis of conditions, so that an early operation may be performed if appendicitis or obstruction be present—hence the film of the chest.

The pneumonia may be central, and I have repeatedly demonstrated a central pneumonia developing before there was a clinical finding in the chest to suggest pneumonia. Incidentally, I have seen a disappearance of the same condition 24 hours afterward, definitely supporting the "abortive pneumonia" of years ago.

Thus would I end this paper with the earnest appeal that the clinician and the roentgenologist work together in the diagnosis and treatment of the ills of these young patients where time and accuracy mean so much.

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DISCUSSION

DR. JOSEPH BRENNEMANN (Chicago): I want to say a few words with reference to this paper. It is always pleasanter to put down a ditto mark and agree with everything that has been said, but I think one ought to say the opposite if one feels that way.

I agree very heartily with Dr. Alexander that the only way we can accomplish anything about the x-ray situation is where the clinician and the roentgenologist work closely together. There is no other way. You find a lot of roentgenologists who have all sorts of ideas. You find lots of clinicians who are led astray by the roentgenologist. There are a lot of roentgenologists who get no information from a clinician. How are they going to know unless they are told what the clinician has found? That applies to a considerable extent to the matter of thymus. I feel very strongly on the thymus proposition. It has always been an amazing thing to me that, for instance, at Ann Arbor they should find thymus after thymus, innumerable thymuses, and that within a period of four or five years there should be eighty-three cases. I have been practicing this for some time and I have seen a large number of cases. We have something like 25,000 cases in a year at the hospital and I make it a point to see every interesting case in the house. If we have two real cases of thymus a year I am not sure of them. I do not say there are not cases that have a thymus shadow. The mere presence of a thymus shadow does not mean anything to me. I do not think a thymus necessarily means there is any danger in any way. I have never in my life seen a child on whom I or anyone else has diagnosed a thymus that died a sudden death afterwards.

We have in the children's hospitals from one to three post mortems a week. I don't know of anything we are more interested in than in thymuses. The thing comes up perennially. We had a child with a comparatively large thymus; the child died very suddenly, but it had had a very severe diarrhea such as we see untold numbers of all the time. I had another that died rather suddenly, but it had a streptococcus throat. If that child had died in my office and had been post mortemed, they would have found a thymus and would have called it a thymus death.

Day before yesterday we had a clinical-pathological conference at which I was not present. They said a child had a thymus death. It was ten months old; it never had had one symptom of thymus since the day it was born. It had meningitis. Because it died within an hour of the time it got into the hospital and had a large thymus, the rest of them said it was a thymus death. I don't think it was a thymus death. We don't know whether these cases die because of a thymus. If they do die because of a thymus, why do they die? I have never yet at post mortem or anywhere seen a single evidence of compression of the trachea. I think that can be excluded. I think there is some peculiar condition of the body or something, but when we say that, we are just pushing it back and are using an expression only.

The largest thymus that I ever saw was in a child in the children's hospital for five years with never a symptom referable to the thymus. It died and we had a post mortem with a thymus as large as my fist, and that child had never had one single symptom of thymus.

I have yet to be completely convinced as to the universality of sudden death because of the thymus. I don't believe it. I believe you will find something else the cause.

Just a word about the x-ray diagnosis. I have for years not used the x-ray diagnosis in pyloric stenosis. I believe there is one criterion and only one as to whether to operate on pyloric stenosis, and that is how is your baby getting on. I think any external help of any sort is misleading. I have never yet seen an x-ray diagnosis that is actually characteristic. To my mind it doesn't tell you anything. Clinically, is your baby getting along or isn't it? If it doesn't get along, operate.

Just one word with reference to whooping cough. What I would like to know is how on earth anybody is going to tell in the second or third week whether you are getting improvement or not getting improvement in whooping cough.

Otherwise I agree with the paper.

There is one little point that ought to be emphasized. The ordinary congenital stridor that occurs in the nursery in the little baby that goes uukuukuuk is never a thymus, that is due to a malformation or some peculiarity of the larynx and has nothing to do with this.

DR. H. F. HELMHOLZ (Rochester, Minn.): I also would like to say just a word with regard to my experience with the thymus gland. I practiced in Evanston for ten years and have been practicing in Rochester for five. I have never during those fifteen years seen a single case that I felt had symptoms of an obstruction or stenosis which were due to a thymus gland.

I have seen in this time three sudden deaths in which at autopsy a large thymus was found. I do not feel, however, that the thymus gland of itself was the cause of the death.

I quite agree with what Dr. Brennemann has said, that there is a status thymo-lymphaticus in which very probably acute infections can bring about very sudden death.

In a study that we are making at the University of Minnesota a considerable number of cases that have been studied of so-called sudden death have been the result of an infection which could be demonstrated by blood culture. I think there can be no doubt that the thymus gland is the one organ in the body whose size is so dependent upon the nutritional condition of the child, and any child dying suddenly is usually in good nutritional condition, so that the tendency for sudden death to be associated with a large thymus is very evident.

Just one word with regard to the symptomatology. I think the point that Dr. Alexander made of a stridor which was both inspiratory and expiratory is the kernel of the thing he has emphasized in a diagnosis of an obstruction due to the thymus gland. I think that is the most important criterion we have for an obstruction due

to the thymus glands; in other words, an anatomical obstruction is bound to be just as great in one direction as it is in the other unless it is valve-like, and that we know is not the case.

If we will stick by that and the criteria will be sharply limited to definite evidence of obstruction, I am willing to believe that those are thymus glands, but personally I have not seen a single case in the last fifteen years.

DR. W. G. ALEXANDER (Evanston, Ill.): One of the first sentences in the paper was that this was the combined work of four pediatricians and myself in Evanston. I might say that I am not strictly a roentgenologist. We have that department, and my own work is practically diagnostic medicine, but the department has handled a great many of these cases.

I don't believe any roentgenologist has any right to diagnose a case as obstructive thymus without the corroborative testimony of the pediatrician. I don't believe that any x-ray film in itself is sufficient evidence, because I have seen films on the same child at one time look like an enlarged thymus and at another time like a normal thymus.

There is something peculiar in coincidence. I think in medicine it is extremely difficult sometimes to separate cause and effect from subsequent events, and I don't think we have necessarily any more shrewd men among the pediatricians in Evanston than any other town, but these cases have all been sent in to me by pediatricians and they have been sent in because they had some symptoms which they could not explain.

Dr. Helmholz mentioned one important symptom to which I should like to add another; one is choking in nursing and the other is the inspiratory and expiratory stridor.

I will not make a diagnosis of obstructive thymus and treat that child unless the child is sent in with symptomatology which the pediatrician feels may have been due to some obstruction due to pressure. We must remember, too, that there are two distinct types of thymus. One is the flat, pancake type, as I call it. I think that can be almost across the chest without producing symptoms, because it is thin. The other is what I call the sausage shape; it is long from front to back. In a film taken in the anterior-posterior position that thymus may look absolutely normal or even smaller than normal. At the same time the child may show distinct symptoms. A lateral view will sometimes show that, as Herrick of Ottumwa says, although I feel that is a very unsatisfactory thing. But these children have not been diagnosed and have not been treated alone on the x-ray findings; they have been treated on a combination and the symptoms have disappeared under the x-ray treatment.

I don't want to be an iconoclast in medicine. I think that an iconoclast is an extremely dangerous fellow, but I am just simple-minded enough that when I treat a child and get results I somehow think maybe the treatment had something to do with it. I know there are times that children get well without treatment, but I have not lost the old-fashioned clinical medicine idea that when I do something and the result follows, maybe the two are associated.

Even my technician in the laboratory has the thing lined up. These patients are not just the little three or four weeks babies; we see the same thing in neglected children up to eight, nine or ten months, or older. We have had the fortune to have three sets of twins sent to us. In each case one child showed the large thymus, the other did not show it. In each case the large thymus was in the younger twin. Whether maturity has anything to do with it I do not know; whether the lack of nutrition or whatever may follow in the lesser of the twins is the cause, I don't know. I have not seen anybody else report twins, but all three sets that we have had showed one large thymus and the other was absent, and in all cases the older twin was the one that was free from it.

It was shown several years ago that the extract of the thymus gland injected into rabbits produced a distinct asthma with death. I don't think just the size of the thymus is all there is to it. I think there must be something more than that. I think an over-sized thymus not only may produce pressure, but there may be a hypersecretion of some kind and I think some of the men who are working on asthma feel that they have something like asthma at times from oversecretion of the thymus gland. There is something else to couple up with that thymus, but if we can reduce the activity of the thymus just as we reduce the activity of the thyroid by x-ray (and I think there is no question that can be done), then I believe we are reducing the oversecretion or overactivity of that thymus and thereby relieving this condition in the child.

When I was an intern I had the misfortune to give an anesthetic to a thymic child, and it died promptly under the anesthetic, through no fault of mine. It threw the fear of God into my soul, I suppose, about thymus glands, so when this thing came up naturally my mind turned toward that phase. It has been an extremely interesting study to me.

Of these 108 cases that have been sent in, not one of those children has been sent without symptoms, and of the 108 I think sixty-eight have been treated; the others were considered by myself as sufficiently negative to say I did not think we ought to treat them, and they were returned.

There is one other question about pyloric stenosis. This, again, is worked only with the pediatricians. In place of the old motor-meal we use the x-ray. That is all it is, but it tells us exactly how much activity there is or how it compares with the normal child. We use mother's milk, by the way.

EPHEDRINE IN ASTHMA AND HAY-FEVER

The value of ephedrine, as shown by its use in 110 cases of asthma and twenty cases of hay-fever, is stressed by George Piness and Hyman Miller, Los Angeles (*Journal A. M. A.*, Aug. 13, 1927). It is said to be a drug of considerable value in the symptomatic treatment of this disease but falling far short in its effectiveness as compared with epinephrine. A study of the results of the use of ephedrine sulphate in twenty hay-fever patients shows that it is a drug of considerably greater value than ephinephrine as a topical application.

Minor Back Injuries

By RALPH M. CARTER, M. D.
Green Bay

In recent years, as we all know, due to various factors, many phases of medical practice have undergone radical changes. One of the most important of these factors, and one with which we have had constantly to reckon, is workmen's compensation legislation. This legislation has brought to us, as physicians and surgeons, many cases of minor injuries which formerly would have been disregarded by the patient, or treated by him with home remedies, with no loss of time from work. Under the circumstances of the present day, however, all injuries are, and properly should be, sent immediately to the surgeon. Since these cases all have a potential medico-legal aspect, it has become necessary for us to clarify our ideas in regard to many conditions: the necessity for rendering reports and testifying in court requires close observation, thorough examination, clear thinking, and exact choice of words, and the requirement which we have upon us of estimating partial and permanent disability, of evaluating the symptoms complained of by the patient in the light of the findings upon physical examination, has led to a search in many directions for definite standards upon which we may base our opinions.

Among injuries which have fallen into ill-repute, principally through lack of standards for comparison, are those to the back. The rather unsavory character which back injuries bear is further contributed to by the varying, frequently diametrically opposite mental reactions which they excite on the part of the claimant, the insurance company, and the examining physician. The claimant looks upon them with apprehension: he fears permanent disability, or at least, lessened earning power; if he is of average intelligence, he knows that there is little physical evidence of his disability, consequently he feels that he must convince the physician that he has been injured; this leads to exaggeration of symptoms on his part, unconscious exaggeration, in most cases, it is true, but still present in such a sufficiently large number of cases that it must always be suspected and ruled out. Since claims for back injuries are very frequent, since malingering may often be proved, and since the evidence of injury is often very vague, if not actually conflicting, the insurance company's attitude is one of doubt. Upon the physician falls the duty of correlating the subjective symptoms with the physical findings: since the latter are frequently conspicuous by their absence, and since the former are just as frequently overemphasized, this gives rise to a great disparity, and induces in him an attitude of suspicion.

Frequently having occasion, in the course of my work, to express a definite opinion as to the presence or absence, and, if present, the extent of back injuries, and realizing the more or less chaotic condition of affairs outlined above, for some time I have been studying the problem in an endeavor to work out some method of examination, satisfactory to me at least, by the use of which I might be enabled to formulate conclusions with an approximate degree of accuracy and definiteness. In this paper, I wish briefly to discuss the subject; I do not feel that I have anything particularly new or original to offer, and I do not pretend to give definite rules by means of which the disability present in each given case may be exactly ascertained, but it will do no harm to call attention once more to certain facts, and to emphasize them. I shall not attempt to consider the more unusual and severer forms of spinal injuries; it is in the minor ones, frequently cases seen in the office, that difficulties and doubts in diagnosis arise; often the question is simply one of deciding whether we are dealing with a so-called "lumbago," whether the condition is purely a traumatic one, or whether both elements are present. It is with cases of this character that I am here concerned.

The complaint which brings the vast majority of these patients to us is pain—pain usually in the lumbar region. Even though the history be apparently clear, we should not make our diagnosis on this history alone. The question which must be decided is, whether an actual injury has occurred, or whether the symptoms complained of are due to conditions elsewhere in the organism having no relation to trauma.

By some authors, all these pains in the lumbar region, or in the back in general, are classed as lumbago, this latter condition comprising a rheumatic and a traumatic form.

With the rheumatic form we are all familiar. It is a condition, and not an accident. It is subject to remissions, it is aggravated by damp or

stormy weather, and appears to be a special form of so-called muscular rheumatism, probably dependent upon focal infection. Unfortunately for purposes of diagnosis, it is not always spontaneous; an effort, a pronounced bending of the body while working, a so-called false position, may excite it, although it must nevertheless still be considered non-traumatic.

TRAUMATIC ORIGIN

The other variety is entirely traumatic, a "strained back." Since postmortem findings are not available, it is difficult to say exactly just what it represents. It usually results from an exaggerated or violent movement of extension or flexion of the spinal column, leading to distention, elongation, or rupture of certain muscle fibers. That rupture occurs can readily be believed, since we occasionally have the late appearance of a discoloration, due to ecchymosis; distention or elongation are more or less theoretical. Likewise, the injury may not be exclusively confined to the muscles; occasionally ligaments may be damaged, constituting a sprain of the spinal articulations.

Many other conditions may give rise to pain in the lumbar region. I do not intend to enter into differential diagnosis in this paper, but will merely mention vertebral tuberculosis, osteomyelitis, vertebral cancer, syphilis, cord lesions, affections of the lungs and pleura, kidney disease, and diseases of the female genital organs. When all these conditions, and in addition, possible foci of infection elsewhere in the body have been ruled out, we may be fairly sure that we are dealing with a traumatic condition. This is rendered more certain if the pain has appeared suddenly following an effort, if it is excited by pressure and movement, and if it is unilateral.

Why is it that the muscles of the back are more liable to strain than the muscles elsewhere in the body? Why is it that some strains are associated with immediate pain, while others are not? These are questions which readily suggest themselves. McKendrick, (1) discussing the anatomical and physiological aspects of back injuries, argues very convincingly that the answers are to be found in certain peculiarities in the spine, both of structure and function. The substance of his reasoning follows.

ANATOMICAL CONDITIONS

From an anatomical standpoint, the spinal column is admirably constructed so as to combine the maximum amount of strength and mobility compatible with lightness. The individual vertebrae are in close apposition by means of their articular facets, while the intervertebral discs, in addition to serving as buffers or shock-absorbers, allow a certain amount of sliding motion of each vertebra on its fellow. Each articulation is held firmly, and is restricted in its range of motion by the strong capsular ligaments. The transverse and spinous processes give attachment to muscles and ligaments, thus additionally strengthening the whole, and all these muscles are very strong and powerful. The fascial planes are also of importance: they serve to separate the various muscle-groups, form channels in which the muscles may act, thus preventing "bow-stringing," and also offer points of origin for muscles. In the spinal column as a whole, there are also present three curves: one in the cervical region, with its convexity forwards, another in the dorsal region having its convexity directed backwards, and a third in the lumbar region, with its convexity again directed forwards. These are developed as a result of the upright posture, and serve a very important purpose in absorbing shocks, as well as in maintaining the center of gravity.

From an architectural standpoint, the spine is thus seen to be excellently adapted for the functions it has to perform, within normal limits; when these limits are exceeded, however, this very structure gives rise to some mechanical disadvantages. These are readily apparent if analyzed in the light of our knowledge of physics.

As mentioned above, several curves are present in the spinal column, and we know that a weakness, in a mechanical sense, exists at the point of junction of curves.

A mechanical weakness also exists at the junction of a flexible with a less flexible structure, and at the junction of two movements. We have such a condition present in the junction of the inflexible vertebrae with the intervertebral discs, and likewise in the various portions of the spine, as in the junction of the flexible cervical portion with the relatively inflexible dorsal portion, and in the junction of the latter with the more flexible lumbar region.

We also know that in a long structure, a weakness exists at its middle, which is equivalent to saying that the strain is greatest at its middle.

Several constrictions are also present in the spinal column, and these constitute a source of

weakness. The width of the column increases from the coccyx to the top of the sacrum, diminishes to the fourth dorsal, increases to the seventh cervical, and again diminishes to the first cervical vertebra.

If these several points are kept in mind during the course of an examination of a patient, in many cases a much clearer understanding of the condition present will be obtained.

The violence producing back injuries may be either extrinsic or intrinsic. The former, as a rule, produces severe injuries, with which I am not concerned in this paper. Briefly, it may be said in passing, the extrinsic violence may be direct or indirect, depending upon whether the injury is produced at the site of application or at some distance from it, and the force may be such as to produce pronounced flexion, compression, shearing, torsion, or a combination of these.

Intrinsic violence producing back injury is usually the result of muscular action. The commonest site of the lesion produced is in muscle; it is less common in ligamentous structures, and is rare in bone.

All voluntary muscles throughout the body have a more or less fixed point of attachment to the bones, which constitutes what is known as the origin. As a rule, to give greater strength, this is fairly extensive. The insertion, or point of attachment to the movable bone, on the other hand, is generally much smaller, and is accomplished through the intermediary of a tendon. This holds true for most of the long muscles of the extremities, where each muscle is individual in its action to a large extent, and where each muscle forms a definite entity. The tendinous attachment to the bone is extremely intimate, the fibers of the tendon apparently growing right into the bony surface. The junction of muscle and tendon is likewise very intimate, and in no way abrupt. The tendon fibers continue into the muscle and gradually become lost in its substance, thus giving great strength to the junction; nevertheless, as pointed out above, a tendency to weakness exists at the junction of an elastic with an inelastic structure, and when a muscle ruptures, it does so at this junction.

Conditions in the back muscles are relatively much different. No actual tendon exists. Instead of a simple muscle acting between two bones, we have the erector spinae, a large mass of contractile tissue. While names have been given to various parts of it, yet no hard and fast line of demarkation can be distinguished between its components, and it serves its function best by acting as a harmonious whole. Over its entire extent it is attached to numerous bony processes and fasciae: since it has so many attachments, it is unnecessary that each one be as strong as those in the extremities.

In gradual and well-ordered movements, as in rising from a stooping posture, all parts of the muscle work in harmony, and no undue strain is brought upon any of it. In lifting weights, on the other hand, greater strain is brought upon the lumbar region. The weak junction of an elastic structure with an inelastic one is always present, consequently some of these points of attachment may rupture, constituting a "strained back," and one almost invariably associated with immediate pain.

Several physiological factors are also present which predispose these muscles to strain. A muscle in a state of fatigue is more easily strained, and prolonged use induces fatigue. That this factor is active, is shown by the fact that back strains show a definite tendency to occur nearer the end of a man's working shift than in the beginning.

Prolonged overstretching of muscles also predisposes to strain, and this is present more often in the back than in any other group of voluntary muscles.

In any muscular action, two sets of muscles are employed, namely, an active group and an opposing group. If one set of muscles is suddenly called into action, it may give way, or if its opposing group is suddenly and unexpectedly called upon to stop that action, one of them may give way. The latter condition is present during the performance of a heavy lift should the rope break, or the foot or the grip suddenly slip.

Ligament injury in the spinal column is practically always the result of external violence, and does not arise under any of the conditions just described. The ligamenta subflava, extending between the neural arches of the vertebrae, possess elastic fibers. They have no inherent power of contractility, consequently they cannot be subjected to intrinsic strain. The ordinary ligaments about the spinal joints are composed of non-elastic fibrous tissue, and to make up for this lack of elasticity, they are provided with an amount of slack sufficient to allow for the normal range of movement in the joints which they surround.

Consequently, they are not put upon the stretch until the limits of this normal range of movement is reached. Injury to them usually results from slow, but excessive bending of the spine.

Having thus very briefly discussed the chief anatomical and physical aspects of back injuries, and hinted at the pathological conditions present, let us now take up the consideration of the examination of the patient.

EXAMINATION OF PATIENT

To examine an injured back and to form a definite and clear-cut idea of the conditions present is a difficult task. As a rule, there is far too much tendency on the part of the examiner to take the patient's account of his injury at its face value. His demeanor while dressing and undressing, his status and gait, his conduct when he thinks he is unobserved, while in themselves too insufficient and indefinite a basis upon which to found a scientific opinion, all are important, and should be carefully observed.

Strained back is the commonest form of back injury, and it is at the same time the most difficult of accurate diagnosis, on account of the scarcity of physical signs. Consequently, every available means of diagnosis must be adopted. If this is not done, when we are through, we may find that instead of having made a diagnosis, we have simply allowed ourselves to be convinced or not, as the case may be, that the patient's complaint of symptoms is true.

The first step in diagnosis, in the back, as elsewhere in the body, is the determination of the tissue which has been injured—skin, fibrous tissue, muscle, bone, joint, or whatever it may be.

A lesion in muscle gives rise to pain when that muscle is thrown into action, a lesion in fibrous tissue when the fibrous tissue is put upon the stretch, a lesion in bone or joint on all movements of the spine.

In all back injuries, the history is of great importance, as from it we can usually obtain much information regarding the mechanics of the injury. If the case be one of alleged strain, the patient should be asked to put himself into the exact position he occupied at the time the strain occurred. Pain will almost certainly be thus caused; the posture should be carefully studied in an endeavor to determine which muscles were in action at the moment of the alleged strain.

If the case be one in which the violence has been applied from without, its exact nature and direction must be inquired into, whether it was a sharp blow, or a force which continued to act after the back had been struck. Here again the attitude of the patient at the moment of injury is important.

Every back injury is the result of some definite mechanical violence applied to the back intrinsically or extrinsically, and such violence must necessarily have some definite mechanical result. In other words, given the nature of the violence, and knowing the mechanical architecture of the structure on which it falls, the mechanical result can in a large measure be foretold. By keeping this fact in mind, much may be learned from an accurate history of the accident.

The symptoms complained of by patients with injured backs are legion, but the important ones, and those worthy of detailed consideration are pain, stiffness, and weakness.

The outstanding one, and the one which is practically always given as the reason for incapacity, is pain. Pain guides the physician to the seat of the injury; it is the outward expression of the pathological condition within, and in a genuine case should be proportional to it. It may be relieved or intensified by various circumstances during the course of the examination, by pressure, movement, relaxation, etc. Since it is a purely subjective symptom, there is consequently no way of measuring it with mathematical accuracy, and for its very presence it is necessary for us to accept the patient's word, in large measure. However, much can be learned from the patient's description of it, whether it is constant, whether it is local or referred; dull, severe, throbbing, or burning; we can find out whether certain movements intensify or relieve it; and finally, there are certain general concomitants of pain which should be looked for, such as increase in pulse rate, elevation of the blood pressure, dilatation of the pupils, alteration in facial expression, characteristic attitudes adopted to relieve or protect the painful part.

Stiffness may occasion disability ranging from a simple lessening of agility to actual rigidity. The range of movement may be restricted by pain, by reflex muscular spasm, or by actual structural change. Every effort should be made to determine its cause and extent.

As a rule the weakness complained of is a more or less subjective condition. In the usual case, no actual weakness exists, except the disability occasioned by the pain and muscle spasm. In rare

instances, however, muscle atrophies may be apparent, or if not apparent, may be capable of demonstration by electrical testing. With these we are not now concerned.

In proceeding with the examination, the patient should be stripped and should be inspected from in front, and from behind, as well as laterally. Scoliosis and kyphosis should be looked for, and if present, the cause should be searched for, in an effort to determine the relationship, if any, to the present accident. Characteristic attitudes should be noted, and their causes considered. Care should be taken to differentiate between attitude, which is a posture assumed by the patient, and deformity, which is due to structural change. The condition of the normal curves should be investigated. A disappearance of these normal curves, leading to a bowing of the entire spine, indicates a chronic sponylitis, and is not the result of accident. On the other hand, an exaggeration of the lumbar curve may indicate an injury to an intervertebral articulation. Rigidity of localized portions of the spine may also be noted, occurring as a result of muscle spasm, in an involuntary effort to protect injured or inflamed tissues.

Palpation should be performed both while the spine is at rest and while it is undergoing motion. Areas and points of tenderness should be searched for, and any rigidity noted on inspection still further investigated. In all cases of true back strain, muscle spasm to a greater or less extent is always present, and constitutes one of the most positive and definite physical signs of injury; consequently it should always be exhaustively searched for. The patient should be made to bend forward, backward, and laterally, and also to rotate the spine. Any restriction in any of these movements should be carefully watched for, remembering that most of the flexibility of the spinal column is in the cervical and lumbar regions, being practically absent in the dorsal.

IMPORTANCE OF X-RAY

In all back injuries, with the exception of those which are obviously of a very trivial nature, the importance of the x-ray in diagnosis should not be neglected. At the same time, while invaluable assistance may often be obtained, the fact should be emphasized and not lost sight of, that unless great care is exercised, we may frequently be led far astray. In the first place, a radiograph of the spine, to be of value, must be a good one; this is absolutely essential. By this, I do not mean only that it must be clear and excellent from the standpoint of photography, but it must be taken at the proper angle so that it will show as plainly as possible the region desired, with the minimum amount of distortion. Stereoscopic skiagrams are much to be preferred, and both anteroposterior and lateral views should be taken. I am inclined to believe that a poor radiograph is worse than none at all. In the second place, the physician must bring to the interpretation of spinal radiographs, a certain amount of experience and knowledge of the variations which occur. In no other region of the body are anomalies and malformations present so frequently as in the spine, particularly the lumbar spine. If the conditions met with fairly commonly are not known, unless great care is exercised, it is a very easy matter to interpret as a fracture of some part of a vertebra, a congenital defect having no relation to the accident or symptoms complained of. This was well illustrated in a case which I saw in consultation not long since. A man fell from a height of about fifteen feet to the ground, striking first on his head and shoulders in such a way as to cause forced flexion of the spine. His chief complaint was of pain in the lumbar region. He was taken to the hospital, and a radiograph made; from this, his attending physician made a diagnosis of fracture of the fourth lumbar vertebra. When I examined him, about ten days after the accident, he could move about fairly well, although he still had pain in the lumbar muscles, associated with some localized rigidity and pain on palpation. All symptoms were fairly mild, however. Examination of the radiograph revealed a failure of fusion of the neural arch of the fourth lumbar vertebra: undoubtedly a congenital defect having no relation to the accident. The condition has been mistakenly interpreted as a fracture.

Probably the most frequent, and certainly the most celebrated of these anomalies is the so-called sacralization of the fifth lumbar vertebra. The condition is characterized by the fact that in certain individuals one or both of the transverse processes of this vertebra have taken on an exaggerated development which may even go so far as the establishment of an articulation with the ilium. This condition, when present, has been invoked to explain the continuance of lumbar pain following an accident. That in certain cases it may give rise to painful affections is undoubtedly true; that these painful affections may occasionally be initiated by trauma is also true; but I do not believe

that every case of persistent lumbar pain in which sacralization may be demonstrated by x-ray is the result of this sacralization.

An entire paper might easily be devoted to this subject of variations and anomalies in the lumbar and sacral regions of the spine. As showing their extreme frequency, I will merely state that I recently examined fifty radiographs of the spine from St. Vincent's Hospital. These were entirely unselected, and no attempt was made to look up the clinical histories. Forty per cent of these fifty films showed sacralization to some degree; thirty per cent showed asymmetry or defective closure of the arch of the last lumbar; ten per cent showed a tendency to the formation of bony exostoses, indicating a chronic inflammatory change. Utilize the x-ray in the diagnosis of back injuries, but be alert for anomalies in the bony structure of the spine, and if any are present, be very cautious about attributing symptoms to them; above all, beware of the fifth lumbar vertebra.

SUMMARY

I have now indicated and briefly discussed what appear to me to be some of the more important factors connected with the occurrence and diagnosis of back injuries; no attempt has been made to treat any of them exhaustively; for example, much more might be said upon the subject of focal infection in relation to these injuries, since it must enter into consideration in every case of disability from lumbar pain which lasts more than a few days, but an entire paper might be written on this subject alone. I believe the following conclusions are justified:

1. Minor back injuries are of importance to the general practitioner on account of their frequency, on account of the often prolonged disability occasioned by them, and on account of their medico-legal aspects under the workmen's compensation act.

2. Many cases of back pain, or "lumbago," which present themselves with a history of accident, are nevertheless not due to trauma. It is the duty of the physician to differentiate these from the traumatic cases, so far as he is able. This cannot be done without taking a complete and detailed history, followed by a careful and searching physical examination.

3. The vulnerability of the back to strain may be explained in large measure by reference to certain mechanical and structural peculiarities and weaknesses arising therefrom. These should be kept in mind during the examination of a patient, and will often assist in diagnosis.

4. Radiographs of the spine, while often of great value in diagnosis, must nevertheless be interpreted with great care, since anomalies of the bony skeleton which may lead to false conclusions are very frequent.

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Abdominal Surgery; Reducing the Risk

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Surgical risk has come to mean infinitely more to the surgeon than the condition of the patient's heart, arteries, lungs and kidneys. The importance of the time factor in the acute surgical abdomen is a matter of common knowledge. Delay in operating, or time wasted during a major surgical procedure, is that much reserve stolen from a patient's vitality. Proper and careful anesthesia, large incisions to avoid undue and dangerous traction on nerve plexuses; and the one prime purpose of the operation—to get in, get after the lesion, and get out as quickly as possible—are the sine quo non to be kept uppermost in the mind of every surgeon. However, we are particularly concerned in this paper with certain most important factors only too often overlooked in the estimation of surgical risk. These factors shall be elicited in the following discourse on the preoperative and postoperative care of the surgical patient.

PREOPERATIVE TREATMENT

Let us first consider the surgical patient preoperatively. We are contemplating a gastroenterostomy or cholecystectomy in a patient with long standing gastro-duodenal or gall bladder disease. Certain factors in the history are of paramount importance in establishing our preoperative regime.

1. The duration of symptoms.

2. Has the patient been vomiting? What is the severity and type of vomiting?

3. What diet has been the patient's food basis?

4. What medication has been taken? Particular inquiry should be made in respect to the ingestion of alkalies.

We generally find that this type of patient has long been on a perverted diet—has been vomiting—and has probably ingested large amounts of alkalies over many years. The perverted diet has resulted in a perverted metabolism. The vomiting constantly depletes the gastric HCL. This HCL is normally neutralized by the alkali of the intestine. and returns to the blood in the form of NaCL. If the HCL fails to follow this normal channel, but instead is lost, alkali accumulates in the blood stream, and the blood chlorides fall. The patient is consequently suffering from an alkalosis and hypochloremia. In addition, the ingestion of large amounts of alkali as a therapeutic measure has served to increase the alkalosis. We are dealing, then, with a patient presenting a perverted metabolism, a low blood chloride, and an alkalosis. It is the alkalosis which aggravates and perpetuates the symptoms initiated by an upper gastro-intestinal lesion. Here is the important factor in the estimation of the surgical risk in this type of patient. The heart, lungs, kidneys, and blood pressure may be perfect, and the patient be a very, very poor surgical risk. Operation without correction of the alkalosis and hypochloremia means a dangerously ill patient post-operatively, with death from alkalosis highly probable. Directing our preoperative treatment towards the correction of the alkalosis and hypochloremia, we advise the following regime:

1. Hospitalize the patient.

2. Place the patient on an easily assimilated, high caloric diet.

3. Study the blood chemistry, stressing the blood chlorides, alkali reserve, and blood urea.

4. Discontinue all alkalies.

5. Gastric lavage for the vomiting is necessary.

6. Saline by mouth—rectum—subcutaneously—or intravenously. Normal to 1.8 to 3 per cent saline may be used. The latter route is preferred if the patient is severely alkalotic and dehydrated. This forcing of saline should be kept up until a normal, or approximately normal, blood chloride, alkali reserve, and urea are reached. This can be determined only by continued blood chemical examinations. Generally, as the blood chlorides rise, the alkalosis diminishes. The approach to normal blood alkali reserve generally marks cessation of vomiting. If, with the alkali reserve and blood chlorides brought to normal, we still feel the patient is not properly prepared for operation, transfusion of 10 per cent glucose (500 c. c.) in 1.8 saline (500 c. c.), or whole blood, the day previous to operation, are indicated. This preoperative regime generally requires two days to one week. At the end of this time we have a patient properly prepared for operation—a patient who has been transformed from a poor to a good surgical risk. The preoperative regime here outlined should be followed wherever indicated and available—and provided no emergency surgery is indicated.

THE EMERGENCY CASE

We now turn our attention to patients in whom emergency surgery is indicated. Consider a case of *acute intestinal obstruction.* While waiting for the operating room to be prepared, the following procedures should be instituted:

1. Treat shock if present.

2. Gastric lavage with normal or 2 × normal saline.

3. Apply external heat.

4. Morphine.

5. Saline intravenously—normal—1.8, or 3 per cent. Here we have no time to wait for blood chemical procedures, but we know from experience in many similar cases that we are dealing with an alkalosis and deficiency in blood chlorides. From 500 to 1500 c. c. of normal to 3 per cent saline should be given intravenously preoperatively, and given rapidly. Here again, a poor surgical risk is transformed into a good surgical risk. This same preoperative regime, slightly varied to suit the individual case, may be used to great advantage in treating the ruptured appendix or perforated ulcer preoperatively—in fact, it is the preoperative treatment of choice wherever a general peritonitis is present, for peritonitis, to us, generally spells ileus. Where we are dealing with an acute abdominal emergency other than an acute obstruction, glucose may be given with the saline to great advantage. During the operation, in severe cases, or where no preoperative treatment has been instituted, saline, or glucose and saline, should be given intravenously or subcutaneously. Also, at the operation, 500 to 1000 c. c. of normal saline may be left in the peritoneal cavity. This is handily carried out by introducing a catheter

through the peritoneum just before the last peritoneal stitch is inserted, and pouring the fluid per funnel through the catheter. General peritonitis is by no means a contraindication to this procedure.

ENTEROSTOMY

We cannot speak too highly of this procedure. In our experience, the end picture in the fatal acute surgical abdomen has been quite constant and uniform. The abdomen becomes increasingly distended—vomiting persists, and becomes fecal in type—the pulse rises rapidly—and the patient passes into a profound, deadly alkalosis. Whether the original condition was a ruptured appendix—perforated ulcer, or acute obstruction—the end picture is generally an ileus. It is also a post-operative ileus which only too often kills the patient who has been subjected to a gastro-enterostomy or cholecystectomy. Is it not logical to forestall this deadly ileus, and do an enterostomy wherever a general peritonitis is present at the time of original operation? The fistula which remains closes very rapidly during convalescence, and many times this is a life saving procedure. A tube in the dependent portion of the peritioneal cavity, and a tube in the gut is a sound principle to follow in general peritonitis. Enterostomy should always be considered in obstinate post-operative ileus. The enterostomy tube not only drains the gut of the noxious substances which throw the patient with ileus into a profound toxemia, but may be used to administer the fluids of which the patient is in dire need. Enterostomy is a relatively simple mechanical maneuver, but far-reaching in its value as a life-saving procedure.

POST-OPERATIVE TREATMENT

Let us first mention a few post-operative principles to be particularly carried out in all gastro-duodenal surgery—as: gastro-enterostomy, resections, and perforated peptic ulcers.

Firstly: In our opinion, fluids should be largely withheld by mouth for twenty-four hours, only permitting one dr. to three dr. doses by mouth every three hours to allay immediate thirst.

Secondly: During this time we constantly feed the patient by vein, using 10% glucose and 1.8 saline in the transfusion. 2000-3000 c. c. (half 10% glucose and half 1.8 saline) are thusly administered in this first post-operative period. On the second day, somewhat larger amounts of fluid are administered by mouth, and the feeding then gradually increased. The food intake should be reduced from the seventh to the tenth day post-operative, for at this time the sutures are being finally absorbed.

Thirdly: We have seen very few cases of post-operative vomiting and hemorrhage in gastro-duodenal surgery, but where they do occur, they are best controlled by repeated lavage with warm normal saline. Wherever the vomiting persists, the blood chlorides should be closely watched, and saline administered as indicated.

Where the preoperative regime here outlined is properly observed, the post-operative treatment is greatly simplified. However, the post-operative complication we are particularly concerned with is ileus. We wish to emphasize again, that it is ileus which is generally the fatal factor in abdominal surgery. It is the persistent vomiting, distention, and rapid pulse—with alkalosis—which generally kills the gall-bladder, gastro-enterostomy, or ruptured appendix patient—(the pneumonia so often found is generally only terminal). We shall not discuss the etiology of post-operative ileus—but—we shall point out how it can be most successfully combated. First of all, let us again repeat, that if the preoperative treatment has been properly carried out, ileus generally does not develop. But where it does develop, let us bear the following in mind:

A—The mild type of distention almost constantly developing in all laparotomies should be treated only by heat to the abdomen, rectal tube, and morphine for the first 24 hours. Before 48 hours, enemas only increase the distention which generally follows opening of the abdomen. At the end of 48 hours, the bowel has regained some of its tone, and now an enema is effectual (S. S. —Milk and Molasses—or 1-2-3 if needed). In our opinion, eserine and pituitrin are of little or no value in the treatment of post-operative distention or ileus.

B.—Treatment of true post-operative ileus:

1. Repeated gastric lavage with normal or 1.8 saline—not soda bicarb. 250-300 c. c. of saline may be left in the stomach once the solution returns clear.

2. A duodenal tube, passed through the nose, and held in position for 24-48 hours, is superior to the stomach tube. It promotes continuous drainage of noxious material, and also aids in the administration of fluids.

3. Follow the blood chlorides, and give normal —to 3% saline intravenously. These patients

rapidly develop an alkalosis and hypochloremia which kills them. Give the saline intravenously, not by rectum or hypodermoclysis, for the saline must be given rapidly, and in large amounts. It is this saline which actually saves the life of the patient.

4. Heat to the abdomen, and a rectal tube.

5. Occasionally, we have had good results with 25 c. c. of 15-25% saline administered intravenously.

These methods generally suffice, and the ileus and alkalosis clear up in 24 hours. Where these procedures fail, they should be combined with enterostomy.

It is our custom to practically entirely abstain from cathartics in our post-operative patients. We particularly refrain from castor oil, which seems to have a rather harmful action in many cases. In the ordinary case repeated enemas post-operatively suffice, though mag. citrate or milk of magnesia, and other mild cathartics may be used.

The post-operative measures we have here outlined, properly and timely instituted, are most potent factors in reducing surgical risk. The surgeon is far from through when the patient leaves the operating room—the post-operative treatment is the deciding factor in abdominal surgery of major import. Formerly our pessimistic prognosis in acute intestinal ileus (mechanical or adynamic) caused us to await the almost certain exodus of the patient. We only contemplated the hopelessness of the situation—and watched the patient pass into a fatal alkalosis. However, in light of our recent experience with intestinal obstruction, we have begun to approach these so-called moribund cases with an assurance that is indeed comforting. The duodenal tube, the ileostomy tube, and the hypertonic chloride solution have become sheet anchors that stay the storm-tossed patient until his natural defenses are again able to guide him to a haven of safety.

SUMMARY AND CONCLUSION

In summary, we stress the following:

1. Gastric lavage: This is a most valuable preoperative and post-operative procedure. The interne should be trained to recognize the importance of vomiting in the surgical patient—preoperatively and post-operatevily. He should be taught that giving the patient soda bicarb or related alkalies to check vomiting, and letting it go at that, is a careless and dangerous procedure. The surgeon must impress the interne watching his cases that vomiting is serious—that it often means an ileus—that neglect means a dangerously ill patient—while early institution of the proper treatment means a rapidly recovering patient. We strongly discourage the use of sodabicarb solution as the fluid in gastric lavage—and suggest normal to 3% saline instead—for it is chlorides the patient generally needs as much as the lavage.

2. Enterostomy: The surgeon very often gets into deep water by a policy of watchful waiting. If we know that certain complications may be expected, let us anticipate them, and enterostomy is the one procedure which prevents fatal ileus. Enterostomy should be done wherever a general peritonitis is present; just to drain the peritoneal cavity is not sufficient. The gut must also be drained—for it is absorption of toxins from the gut itself, due to the associated ileus and concomitant alkalosis, which spells death in general peritonitis. Only rarely, is general peritonitis, unaided by an associated ileus, an infection of sufficient virulence to kill the patient.

3. The duodenal tube: This tube, passed through the nose, and held in position as long as necessary, is a valuable procedue in the treatment of post-operative ileus. Through it, the upper gut is drained of the noxious material, and it also acts as a pathway for the administration of fluids.

4. Prevention of dehydration: Dehydration is the sword which hangs over the head of the surgical patient. The one most essential post-operative procedure is the forcing of fluids—and these fluids must be of the right type. Saline is the fluid par excellence in hypochloremia with alkalosis. Glucose and insulin, with soda bicarb, are to be used in acidosis. Stock solutions of normal—1.8—3% saline, and 5 and 10% glucose should always be on hand. Where there is a crying need for fluids they should be given intravenously, and not under the skin or per rectum.

5. Blood chemistry: There has always been an elusive something which has baffled our prognosis in surgical patients, but studies in blood chemistry have lighted our way—and we are now on the threshold of a more hopeful and favorable position in regard to our surgical risks. A proper conception of the patients blood chemistry leads to more rational treatment of the case. In acute intestinal obstruction, pyloric obstruction, or post-operative ileus, we now know we are dealing with an alkalosis and fall in blood chlorides—and we treat the case accordingly. But in other cases we do not

know what the alkali reserve of the blood is—and an acidosis or alkalosis may be one of the basic factors of the disease. The need for fluids in the surgical patient is generally recognized, but we must also appreciate the importance of administering the proper type of fluid. Soda bicarb should never be given to a patient in alkalosis—it kills the patient. Glucose alone is of very little value in alkalosis—but both glucose and soda bicarb are absolutely indispensible in the treatment of acidosis. Saline is of no value in acidosis, but of paramount importance in treating alkalosis. Would it not be of tremendous value to establish the blood chemistry findings in our surgical patients, and correct the alkalotic or acidotic condition of the blood which may develop pre or post-operatively? Alkalosis and acidosis are conditions easily recognized by certain laboratory procedures, and readily corrected if not too far advanced. The correction of an acidosis or alkalosis is very often a life saving procedure, and the laboratory informs us of the existing perverted blood chemistry. Let us use the laboratory—thus minimize surgical risk—and enhance our patient's chances for recovery.

Toxic Goiter; Cardio-Vascular Manifestations

By LOUIS F. JERMAIN, M. D.
Milwaukee

The disastrous effect upon the heart of thyrotoxicosis is well known. That unrelieved toxic goiter terminates in death from cardiac failure is equally well established. Advanced cardiac disease the result of this toxic state furnishes the physician and surgeon with a group of patients who are hopeless and permanent cardiac cripples; in whom the usual management of cardiac failure is almost wholly ineffective.

If then toxic goiter produces such a permanent and irremediable cardiac condition, it is the plain duty of the physician to prevent advanced "goiter heart" and the resultant incapacity, and death.

The earliest and most reliable symptoms and signs of toxic goiter are circulatory, hence careful observation and study with a view of eliciting these early indications will enable a prompt diagnosis and adequate treatment.

In this connection it is well to remember that cardiac damage may result from a mild toxicosis as well as from the more fulminating and severe types. This mildly toxic state is usually encountered in simple adenomatous goiters that have existed for many years in which pronounced evidence of toxicosis was mostly absent.

We have seen many patients who for years perhaps have had thyro-toxic symptoms not at any time of sufficient severity to attract attention, or to seek medical advice, but who nevertheless, showed advanced myocardial disease and cardiac incompentency of the thyro-toxic type.

Next perhaps to mitral stenosis the most common cause of perpetual arrhythmia, auricular fibrillation and auricular flutter is thyro-toxicosis.

TACHYCARDIA

Perhaps the earliest circulatory disturbance is tachycardia. This is so constant a symptom that a diagnosis without it is hardly permissible. The pulse rate is invariably 100 or above, the rate is very unstable being influenced very readily by mental excitation and physical exertion. Palpitation is seldom complained of in this early stage and the patient may not be conscious of rapid hearts action. If, as is usually the case, pronounced nervous symptoms are present, the early stage of the condition is commonly diagnosed neurasthenia. Tachycardia is constantly present during the entire course of the disease, and perhaps in itself is responsible for much of the subsequent myocardial damage. One can hardly imagine a heart constantly contracting at double the normal rate without signs of exhaustion making their appearance.

HEART SIGNS

Physical examination of the heart shows early, a very forcible tumultous contraction. The apex beat is displaced to the left and the area of absolute and relative dullness is increased. Seldom there is thrill or friction sounds. Very early there is found a rough basal systolic murmur, sometimes a to and fro murmur in this area. The murmur is always definitely short and harsh. There is no accentuation of pulmonic or aortic seconds. The heart sounds are loud and sharp quite characteristic of the heart in thyro-toxicosis.

Later cardiac developments are mainly those resulting from myocardial damage affecting the rythm and contractile efficiency. Disorders of rythm are extrasystoles, pulses alternans, perpe-

tual arrythmia, auricular fibrillation and cardiac flutter. We have not seen any case of heart block as the result of toxic goiter. Relative insufficiencies of course may develop at any time when marked cardiac dilitation supervenes.

Electrocardiographic examination usually shows decided left ventricular preponderance, seldom right sided preponderance. Marked prolongation of the "P." "R." interval indicating impaired conductivity of the bundle of His. A very short rest time or diastolic "T." "P." The "P." and "T.". waves become superimposed which means that auricles contract before the ventricles have relaxed.

X-ray examination of the heart shows marked increase in size horizontally, with almost invariably some widening of aortic shadow. Fluoroscopically marked aortic pulsation is observed. In many cases this is so pronounced as to lead to a suspicion of diffuse aneurism.

VASCULAR MANIFESTATIONS

These are of great importance in early diagnosis and are the result of a decided vasomotor instability and relaxation. There is always a decided flushing of the face with a definite collar of marked hyperemia around the neck and upper part of chest. Always there is marked dermographia. There is very evident pulsation of the vessels of the neck in many instances closely resembling the vascular throbbing of aortic regurgitation or syphilitic aortitis. Patients frequently complain subjectively of this distressing vascular throbbing. There is pronounced vasomotor relaxation often to the degree resembling the Corrigan pulse of aortic regurgitation. Blood pressure readings always show, especially early in the disease before marked myocardial degeneration has occurred; a high systolic, a low diastolic and a high pulse pressure. Pulse pressures of 60 to 80 are not uncommon and are of great significance. There is general vascular relaxation including the aorta both thoracic and abdominal. This can well be proven by x-ray examination of the thoracic aorta and by the presence almost invariably of a dynamic abdominal aorta.

This general vascular atonia undoubtedly gives rise to most of the early cardiac symptoms and signs, as well as the pathologic eye signs in exophthalmic goiter. We have seen the above symptoms entirely disappear shortly after thyroidectomy.

SUMMARY

First: The most hopeless cardiac cripples develop as the result of mild long continued or acute fulminating thyro-toxicosis.

Second: The earliest and most reliable manifestations of toxic goiter are cardio-vascular.

Third: The early cardio-vascular symptoms are frequently attributed to disease other than toxic goiter.

Fourth: The diagnosis can be made and proper treatment should be instituted before irreparable damage to the myocardium results.

THE JOURNAL CLINIC

Proteins; An Interesting Experience

By T. L. HARRINGTON, M. D.
Milwaukee

Previous to 1908 I spent considerable time driving horses. Close contact with horses caused marked itching of the eyelids with lacrimation, followed by severe and long continued sneezing, and later, usually at night, very definite and at times very severe asthmatic attacks. It took me some time to discover that the exciting agent was the dandruff from the horses.

I purchased my first automobile in the autumn of 1908 and after that time I had little contact with horses and little or no trouble from infection with horse protein. During my service in the World War I was obliged to ride horseback at times and noted some of the symptoms described above but had no marked asthmatic attacks.

On Saturday evening of last week I had the palm of my right hand badly lacerated by a blunt hook which was none too clean. After the surgeon sterilized and sutured the wound I asked him to give me a prophylactic dose of tetanus anti toxin, forgetting for the time all about my former experience with horse protein. About thirty minutes after the injection of 1500 units of anti toxin I felt severe itching of the eyelids with beginning lacrimation. This was followed by marked and prolonged sneezing, and in less than fifteen minutes

after the first symptoms appeared I was suffering from a very severe attack of bronchial asthma. The attack lasted about two hours and gradually subsided without treatment. It manifested all of the characteristics of former severe attacks which were provoked by horse dandruff.

The interesting thing in this experience was the fact that the sequence of symptoms—itching eyelids, lacrimation, severe irritation of the nasal mucous membrance causing prolonged sneezing, and later bronchial asthma, appeared in the same order as they had appeared on many previous occasions more than twenty years ago. I am led to the query as to what might have happened if during this interval of time I had had an attack of diptheria or tetanus requiring large, curative doses of horse serum?

Diagnostic Problems

By L. M. WARFIELD, M. D.,
Milwaukee

In the last Journal we had the case of a single woman, 35 years old, who had attacks of abdominal pain, had her appendix removed. She still had pain, then was diagnosed ureteral stricture, was dilated and still has pain. No loss of weight.

DISCUSSION

The reader might wonder why I have chosen this case for discussion when the diagnosis is not positively made in that one has not positively seen or felt definitely the pathological lesion. The case is brought up particularly for the reason that I wish to call attention to what seems to me to be a matter of considerable importance.

So many times when chronic pain in the lower abdomen is diagnosed chronic appendicitis, the patient is operated upon and the pathologist reports often chronic appendicitis. As a matter of fact the appendix probably looked very normal. There were no adhesions and under the microscope one had to strain his imagination to call it infection.

This young woman, it seems to me, belongs to that class of persons who, without ever having had attacks of acute appendicitis, has pain which is thought to be appendicitis. She is operated upon and for a while the pain is relieved, but it comes back much the same and sometimes worse. She now is diagnosed "ureteral stricture," because the catheter seems to stick. She had had no inflammatory pelvic disturbance and no evidence of real appendicitis, so that there was no causative factor for her stricture which usually is the result of ulceration, or of infection starting from contiguous parts. However the dilation not only did not relieve the pain, but the pain seemed to be even worse. She then developed a very characteristic dyspepsia of a selective type and the pain which was at first mostly abdominal, now travels through to the right back. There is also very definite stiffness of the upper right rectus muscle. Some fixation of the duodenum would seem to indicate that there is some gall bladder difficulty. It seems to me therefore that probably the whole process was gall bladder disease from the very beginning. Personally I feel that chronic appendicitis is an uncommon condition as a rule and occurs only following acute or sub-acute attacks. The x-ray visualization of the appendix following a barium meal after 48 or 72 hours has been shown not to be a sign of chronic inflammation.

In women, gall bladder disease is exceedingly frequent. Gall stones have been removed from young women 18 years old or even younger. Stones in the gall bladder is a common condition and whenever it occurs there is opportunity for infection to be superadded.

I think we should be careful not to make the mistake of diagnosing gall bladder too often as we have chronic appendicitis, but there is much more anatomical evidence for chronic gall bladder disease than there is for chronic appendicitis. May she have tuberculosis of the kidney? There is a history of hemoptysis ten years ago, but physical examination revealed no definite evidence of this, and all examination of urine and kidneys, including x-ray photographs, showed no suspicion of tuberculosis.

This patient, I feel, has had chronic gall bladder disease all this time, the symptoms being slightly aberrant, and both the appendicitis operation and the dilation of the ureter could not have helped her, and actually did not help her.

These cases are not easy to diagnose, but one should be particularly careful in diagnosing and removing an appendix in the absence of any history of acute or sub-acute attacks.

A NEW REPORT

A young white man, 31 years old, a sheet iron

(Continued on Page 498)

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There is listed the following definite services that are available to our readers—the members of the State Medical Society of Wisconsin. If you have a need not covered here address the Secretary, Mr. J. G. Crownhart, 153 E. Wells Street, Milwaukee. "Let George do it."

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FOR THE COUNTY SOCIETY

1. *Program Material.* Pursuant to authorization by the 1924 House of Delegates the Secretary is arranging to make program material available without cost. The following can now be secured:

A. Departmental Officers of the State Board of Health. Address Dr. C. A. Harper, State Health Officer, State Capitol, Madison, Wis.

B. Clinicians of the Wisconsin Anti-Tuberculosis Association when in vicinity. Address Clinic Dept., W. A. T. A., 558 Jefferson Street, Milwaukee.

C. Councilors and Officers of the State Society. Address the individual.

2. *Annual Statements.* Uniform annual statements can be had without cost. Address the Secretary, advising number desired.

EDITORIALS

DIRECTIVE EFFORT

IN this issue members of the society may obtain a rather complete survey of what transpired in the field of public health at the last legislative session. As we read of the constructive proposals adopted, we can not help but realize that the time has arrived when the State Medical Society of Wisconsin is leading the way.

For years on end our medical meetings have echoed dissatisfaction with legislation. Time and time again the society has presented worthy measures only to find their recommendations "indefinitely postponed".

Simultaneously with the lay educational campaign, however, we have seen a growing recognition in the public mind of the fact that physicians are truly interested in bettering the public welfare and that they themselves realize that physicians will progress with the public advancement. Legislatures in the final analysis but reflect public opinion and thus we see a report from our committee on public policy which should be a source of pride to every member of our society.

There is much that remains for accomplishment in the near future; there is still more to be accomplished which is as yet in an undeveloped state. This is true, however—our society is now in a position where it is leading the way for the future betterment of the public and profession alike. The cornerstone has been laid and the structure to be erected will be the accomplishment of the architects' vision. Physicians will be the architects.

THE POWER OF THE VETO

IT HAS required many generations to rescue medicine in general and psychiatry in particular from the maze of myth, ignorance and superstition. Medicine has become a more exact science only as the result of diligent and persevering effort on the part of its votaries. Psychiatry has developed more during the past fifteen years than during all the years of its previous history. Those men devoting their lives to the study and care of the mentally ill will not be satisfied until they have these sick individuals properly recognized and cared for, and until the public is properly protected against those who are dangerous because of their peculier mental twist.

That we are still contending with ignorance and superstition is painfully brought to our attention only too often. Such was the case in a recent veto of a governor of a state frequently spoken of as progressive. A bill to abolish the present jury trial in cases of insanity passed both houses and was killed by the veto. The reason given was that this change interfered with personal liberty. If the reason given was due to an honest conviction, we can only remark that it is but another instance of reaching conclusions with a knowledge of but part of the facts. Can one conceive of a greater travesty than that of a group of laymen attempting to pass upon the mentality of any individual? Do we call upon laymen to pass upon tumors or broken bones? Yet this would be a simple task compared to that of passing upon the workings of the human mind, the most complex mechanism known to science. Many cases of insanity are so patent that a child twelve years old could say the subject was insane, but frequently such is not the case. The paranoid types of insanity are often most baffling and show little in their conduct or conversation that could be termed irregular. Their delusions are invariably persecutory, well-organized, and do not affect their conduct to any extent except when conditions bring these delusions into play. Because of these facts, they are the most dangerous insane, and yet are easily overlooked and misunderstood by the average individual. In fact, they frequently put the most experienced psychiatrist to a severe test.

Almost every community has one or more of these dangerous individuals walking its streets with perfect freedom and only after some horrible crime are they apprehended and declared insane, at great cost to the state.

The law referred to above had these individuals in mind, as well as the absurdity of expecting untrained and unscientific minds passing on questions quite beyond their ken. It is better to have these dangerous individuals taken into custody before they commit a crime. If such were the case, our kings, presidents, and other public servants would live longer and more comfortably.

One other point: there is no authentic instance of a physician prostituting his knowledge and position for the purpose of placing an individual in an institution for the insane who did not belong there. The men appointed to such positions of trust by a judge are to be depended upon.

Permit me to quote verbatim from a speech made recently at the meeting of a bar association, by Supreme Justice Humphrey J. Lynch of New York: "The only exception I would make to the abolishment of trial by jury is to reform our present judicial system to provide that in cases where mental competency is the issue, trial by jury should be abolished. Determination of mental conditions is one of the most difficult, complicated, and technical problems with which the human mind has to grapple. The question of the sanity or insanity of an individual ought not to be determined by laymen, however sincere and well-meaning, but without technical knowledge of mental disorders. Such cases should be determined by judges in the light of careful examination and testimony by mental experts who are called, not as witnesses for or against a given defendant, but as experts in the field of mental medicine and qualified to testify as to mental abnormalities in the same way that physicians testify about physical health, engineers about technical engineering problems or architects about architectural issues. A man with a mental disease is not a criminal, but a sick man, and his case should be decided accordingly. The unfortunate victims of mental disease are not committed to prisons in these days, except where they have been proved guilty of criminal acts, but are sent to state or private hospitals for the protection of themselves, their financial interests and the protection of the community."

A. W. R.

CLASS METHOD

THERE has been developed, within the last few years, what may arbitrarily be called a Bostonian class method of therapeutics. It is a practical adaptation into the realm of therapeutics of one of the fundamental principals of mass psychology—that of competition—wherein each patient in the class strives to attain to the level reached by the most progressive in the group.

Dr. William R. P. Emerson, of Boston, has employed this method extensively in problems of nutrition and growth in children; Dr. Joseph Hersey Pratt, also of Boston, in dealing with tuberculosis patients. Many have used it in treatment of enuresis, one child being cured of bed-wetting by the progress of others in the group. Also in the hospital ward,—as for example, in the maternity ward, where one woman will strive to "come back" as quickly as the most progressive in her ward,—the principle of competition has suggested possible further practical application of the class method of therapeutics. Especially is this true in the sanatorium where the boasts of the more progressive patients to the less progressive ones have often served as an incentive for an otherwise recalcitrant convalescent.

Reverting to Dr. Emerson's nutrition classes, the principle upon which these classes are based appears to be group association and personal observation. As children are quick to imitate and to learn from one another, and as the enjoyment of competitive games is inherent in most children, each child will be found to take an active interest in his own chart record, and to strive to keep his above the others. In his "Nutrition and Growth in Children" (page 188), Dr. Emerson says "There is great teaching value in comparing the child at the head of the class with one who has not gained, and explaining the reason for the results in each case. The force of public opinion in the class group can, in this way, be made a powerful ally in removing such simple causes of failure as neglect of rest periods, luncheons, prejudice against open windows, and over-fatigue arising from late hours or unnecessary tasks. Care must be taken, however, not to discuss openly matters about which either parent or child is rightly sensitive."

The results that have been obtained by both Dr. Pratt and Dr. Emerson, through this class method of instruction, show quite obviously the applicability of this system of therapeutics in the case of the clinic physician, the school physician, and the charity doctor. To us it appears that there are also frequent opportunities for the utilization of this method of treating chronic diseases by private practitioners in their handling of private patients. In other words "private" need not be so frequently synonymous with "individual" nor "group" with "charity".

H. E. D.

THE PRESIDENT'S PAGE

Arthur W. Rogers

FOR OURSELVES

FEW ORGANIZATIONS in this country, having for their purpose the welfare of the public, occupy a position of such influence and enjoy such an enviable record as the American Medical Association. A similar statement might be made concerning our state and county medical societies. They are composed of men of action and we find them occupying positions of trust and influence. I venture to say that no profession or group of individuals commands greater respect from the public than does the medical profession, whose purpose it is to relieve suffering and prolong life. This, of course, means leadership, and we should ever be found in the van of every movement to do with the betterment of mankind and the community.

In our pilgrimages about the state, we have been greatly surprised and disappointed to find how few medical men exercise the privilege of regular medical examinations. A nation wide campaign is on at present to stimulate this movement among the laity, and why should we advise our patients to take better care of their health than we do of our own, or that of our families? We should not preach where we do not practice. A good officer leads his troops just as a good chief never orders a fireman to go where he will not lead. A strong, healthy appearing physician is ever a powerful tonic to his patients.

There is an old saying about "shoemaker's children and doctor's wives . . .", and it is high time that we doctors demonstrate our belief in this great health movement by giving more careful and scientific medical care to ourselves and our families.

Because of the nature of our work, we need to be more watchful of our health than almost any other group of men. We understand that the staff, physicians and nurses, of the Mayo Clinic are required to take a complete physical examination every six months. This is leadership.

It may prove embarrassing some time, when advocating the wisdom of periodical health examination, to have our patient enquire when we were last examined.

"Go thou and do likewise."

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Green Lake-Waushara-Adams	Orvil O'Neal, Ripon	J. M. Johnson, Ripon.
Iowa	A. D. Brown, Mineral Point	M. W. Trentzsch, Highland.
Jefferson	W. C. Becker, Watertown	A. C. Nickels, Watertown.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	C. G. Richards, Kenosha	H. A. Binnie, Kenosha.
La Crosse	E. A. Smedal, La Crosse	N. P. Anderson, La Crosse.
Lafayette	W. W. Peck, Darlington	S. A. J. Ennis, Shullsburg.
Langlade	M. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	E. K. Morris, Merrill	W. H. Bayer, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	M. P. Andrews, Manitowoc.
Marathon	W. E. Zilisch, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	M. D. Bird, Marinette.
Milwaukee	C. H. Stoddard, Milwaukee	E. L. Tharinger, Milwaukee.
Monroe	H. B. Johnson, Tomah	H. H. Williams, Sparta.
Oconto	C. W. Stoelting, Oconto	C. J. Ouellette, Oconto.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schick, Rhinelander.
Outagamie	J. B. MacLaren, Appleton	C. D. Neidhold, Appleton.
Pierce-St. Croix	Rolla Cairns, River Falls	J. W. Prentice, Deer Park.
Portage	G. H. Lawrence, Stevens Point	F. R. Krembs, Stevens Point.
Price-Taylor	E. A. Riley, Park Falls	J. D. Leahy, Park Falls.
Racine	W. A. Prouty, Burlington	Susan Jones, Racine.
Richland	J. M. Ross, Richland Center	G. Benson, Richland Center.
Rock	W. H. McGuire, Janesville	H. E. Kasten, Beloit.
Rusk	L. M. Lundmark, Ladysmith	H. C. Johnson, Bruce.
Sauk	H. J. Irwin, Baraboo	Roger Cahoon, Barahoo.
Shawano	R. C. Cantwell, Shawano	C. E. Stubenvoll, Shawano.
Sheboygan	C. A. Squire, Sheboygan	G. J. Juckem, Sheboygan.
Trempealeau-Jackson-Buffalo	George Christiansen, Galesville	R. L. MacCornack, Whitehall.
Vernon	H. J. Suttle, Viroqua	Wm. H. Remer, Chaseburg.
Walworth	B. J. Bill, Genoa City	T. P. Keenan, Lake Geneva.
Washington-Ozaukee	C. A. Balkwill, Grafton	A. H. Heidner, West Bend.
Waukesha	C. C. Edmondson, Waukesha	J. F. Wilkinson, Oconomowoc.
Waupaca	T. E. Loope, Iola	A. M. Christofferson, Waupaca.
Winnebago	S. D. Greenwood, Neenah	R. H. Bitter, Oshkosh.
Wood	J. C. Hayward, Marshfield	V. A. Mason, Marshfield.

SOCIETY PROCEEDINGS

ASHLAND-BAYFIELD-IRON

Dr. F. G. Johnson, Iron River, was elected president of the Ashland-Bayfield-Iron County Medical Society at the annual meeting of the society held at the Elks' Club House on Thursday, July 28th. The meeting started with a luncheon at noon and continued through the afternoon. Other officers elected are: Dr. R. O. Grigsby, Ashland, vice president; Dr. M. L. Young, Ashland, secretary, and Dr. M. S. Hosmer, Ashland, censor.

Mr. George Crownhart, secretary of the State Society, gave an interesting discussion of the matters before the legislature which are of interest to the medical men of the state. Dr. Frank W. Spicer, Duluth, presented an instructive paper on "Dietetics." The meeting was well attended. *M. L. Y.*

MARINETTE-FLORENCE

The Marinette-Florence County Medical Society experienced a wonderful day, Saturday, July 23rd. The Wisconsin Association for the Disabled held a clinic in which eighty-one children were examined, with prognosis and treatment outlined for them. Dr. Frederick J. Gaenslen, Milwaukee, had charge of the work and addressed the doctors after the dinner on "Back Ache," which was received with much pleasure.

Mr. W. F. Faulkner, and Mr. O. J. Dorr, of the State Board of Vocational Education, were present. Mr. Horace J. Nellum, of Kenosha, secretary of the Nash Motor Company, and president of the association for crippled children, was also present and made an interesting after-dinner talk on the work that was being done for these unfortunates. Mr. John Callahan, state superintendent of Public Instruction, also made himself active in the day's program.

Miss Margaret Lison spent a month in Marinette in getting the clinic under way and did most efficient work in doing so. She spoke briefly at the evening meeting. Miss Lison was ably assisted in her work by Mrs. Dudley, city nurse, and Miss Jessie MacDonald, county nurse, and most of the service clubs of the city and county were actively interested.

Dr. Joseph Beck, Chicago, but recently returned from Europe, spoke about scientific medicine on the continent and emphasized that it was wonderful to be home in the good U. S. A., where medicine meant something other than the mere making of a living, which is the status of the professors of Vienna at present. Dr. T. J. Redelings presided, and much credit is due him for his tireless work and energy in promoting scientific medicine and establishing good fellowship among the members. There were several doctors from out of town and the meeting was voted a wonderful success. *M. D. B.*

PIERCE-ST. CROIX

The members of the Pierce-St. Croix Medical Society and their wives had an afternoon and evening outing at Hickory Point on Thursday, July 28th. At 6:30 a delicious chicken dinner was served. It was the unanimous decision of all present to have a similar outing next year.

Those present were: Dr. A. E. Gendron; Dr. and Mrs. Rolla Cairns, Dr. and Mrs. C. E. McJilton, River Falls; Dr. H. P. Conway, Spring Valley; Dr. and Mrs. B. Kunny, Baldwin; Dr. E. B. Bradford, Mrs. Lunde, and Mrs. L. E. Newton, Hudson; Dr. and Mrs. O. H. Epley, New Richmond; Dr. A. E. McMahon, Glenwood City; Dr. and Mrs. J. W. Prentice and Dr. Johnson, Amery. *J. W. P.*

ROCK

Members of the Rock and Winnebago (Ill.) County Medical Societies joined in a delightful summer get-together at the Hidden Inn, south of Rockford, on Wednesday, August 10th. One hundred and twenty-five physicians and their families enjoyed a well planned entertainment between the hours of 12:00 noon and 12:00 midnight. A golf tournament was held in the morning between the members of the two counties and prizes were awarded following dinner. Games for men, women and children were scheduled which included kitten ball, golf putting contest, fifty-yard dashes, sack races, relay races, volley ball, horseshoe tournament and other stunts. Prizes were awarded the winners of the games and a cup was given to the county annexing the greatest number of points.

A chicken dinner was served at 6:30 o'clock in the dining room of the Hidden Inn, and Dr. W. H. McGuire, president of the Rock County Society, presided as toastmaster. Phillip Rhau of Marquette University was the speaker of the evening and a five-piece orchestra furnished music for dancing later in the evening. *H. E. K.*

TREMPEALEAU-JACKSON-BUFFALO

The third annual Mississippi cruise of the Trempealeau-Jackson-Buffalo County Medical Society was held July 28th in Dr. W. J. Mayo's yacht "North Star". Dr. and Mrs. Rowntree of the Mayo Clinic were the hosts representing Dr. and Mrs. Mayo. Dr. Arthur W. Rogers, president of the State Medical Society of Wisconsin, with Mrs. Rogers, were the guests of honor. A short program was held on the boat during the afternoon. Dr. Rogers spoke on "The Nursing Problem" and "Periodic Health Examinations", while Dr. Rowntree discussed "Kidney and Liver Functions". There were about fifty in the party. It was a very enjoyable trip. *R. L. MacC.*

WINNEBAGO

Twenty-two members of the Winnebago County Medical Society were entertained recently at the Walden Farm Dairy on the Butte des Morts road as guests of E. Homer Fahrney. Most of the visitors at the farm were from Oshkosh, but there were also representatives from Larsen and Winneconne.

The medical men were frankly enthused at what they saw at the farm in the nature of modern barns, poultry sheds and other points of interest. *R. H. B.*

FOURTH DISTRICT

An interesting and instructive meeting of the Fourth Councilor District, composed of the counties of Grant, Iowa, LaFayette, Crawford and Richland, was held at the Grantland Club rooms at Lancaster on August 3rd.

The scientific program commenced at two in the afternoon and included: Dr. G. H. Robbins, Madison, "Periodic Health Examination, Talk and Demonstration"; Dr. Arthur W. Rogers, president of the State Society, "The Nursing Problem"; Dr. E. J. Schneider, Madison, "Some Recent Advances in Obstetrics and Gynecology"; Dr. Arnold Jackson, Madison, "Goiter"; Dr. James Dean, Madison, "Recent Advances in Surgery"; Dr. J. C. Doolittle, Lancaster, "The What, Why and When of Tonsils"; Mr. George Crownhart, secretary of the State Society, "Report of Work in the State." Dinner was served at six thirty. *M. B. G.*

NINTH DISTRICT

About fifty physicians attended the mid-summer meeting of the Ninth Councilor District Medical Society held at Wausau on the afternoon and evening of July 28th. A clinic was conducted at St. Mary's Hospital in the afternoon, followed by a six-thirty dinner at the Wausau Club.

The evening program included the following addresses: "The Importance of History Taking," by Dr. Louis F. Jermain, Milwaukee. This was followed by a symposium on tonsillectomy in which Dr. J. M. Freeman, Wausau, spoke on "Indications for Tonsillectomy from the Standpoint of the General Practitioner"; Dr. L. M. Willard, Wausau, "Some Points in the Diagnosis and Treatment of Diseased Tonsils"; Dr. F. A. Southwick, Stevens Point, "Results of Tonsillectomy as Seen in the Routine Examination of School Children." Discussion was opened by Dr. W. G. Merrill, Wisconsin Rapids, and Dr. H. H. Christofferson, Colby. Dr. J. B. Vedder, Marshfield, spoke on "Glimpses of Medicine in Europe."

Dr. H. Raasock, of Nelsonville, is president of the district society, and Dr. Joseph F. Smith, Wausau, is its secretary. *J. F. M.*

ELEVENTH DISTRICT

Dr. C. J. Smiles, Ashland, was elected president of the Eleventh Councilor District Medical Society at its meeting on the afternoon and evening of August 12th. Dr. P. G. McGill, Superior, was chosen vice president and Dr. F. G. Johnson, Iron River, was re-elected as secretary. Ashland will be the place of meeting for 1928.

The physicians met at Hotel Androy, Superior, at 1:30 p. m., where the following program was presented:

Dr. Arthur W. Rogers, Oconomowoc, "Nervous Disorders in General Practice"; Dr. R. I. Rizer, Minneapolis, "Diverticulitis"; Dr. A. M. Snell, Rochester, Minn., "Liver Functions"; Dr. Erwin Schmidt, Madison, "Ventriculography in the Diagnosis of Brain Lesions"; Dr. C. J. Chatterton, St. Paul, "Fractures of the Hip Joint". A banquet was served at the hotel at 6:30, after which the members and guests listened to Dr. Arthur W. Rogers, president of the Society, Dr. J. M. Dodd, councilor of the Eleventh District, and Mr. George Crownhart, state secretary. The Eleventh District is comprised of Ashland, Bayfield, Iron, Douglas, Langlade, Oneida, Forest, Vilas, Price and Taylor counties.

NEWS ITEMS AND PERSONALS

Dr. H. E. Marsh of the Jackson Clinic, Madison, has just returned from a two months' trip abroad, part of which was devoted to pleasure, and part to post graduate work at Vienna.

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The Sparta Clinic has recently added a new physician to its personnel in Dr. Charles F. Foley. Dr. Foley is a graduate of the Marquette University Medical School and has just completed a year's interneship at St. Mary's Hospital, Milwaukee.

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Dr. J. F. Moon opened offices in the First National Bank building at Baraboo on August 1st. He is a graduate of the University of Wisconsin and the University of Illinois Medical School and has been with the Jackson Clinic, Madison, for three years. His practice will be confined largely to pediatrics and internal medicine.

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Dr. A. M. Carr, former Madison health officer, has accepted a position with the Michigan State Board of Health at Lansing. Dr. Carr has been in the East since resigning his Madison position about the first of July.

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Dr. E. L. Belknap, who has been connected with the Ford Hospital in Detroit, will be associated with Dr. L. M. Warfield, Milwaukee, after September 16th.

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Dr. A. A. Hoyer returned to his home in Beaver Dam the last week in July after having attended the Inter-State Post Graduate Clinic Assemblies of North American Physicians in Europe. The assemblies were represented by thirty-seven states of the union and some from Canada, the representatives visiting the renowned medical centers of Europe, and attending clinics and lectures at various points.

The clinic course commenced at New York on May 21st on board the steamship "Celtic." The physicians visited Liverpool, London, Edinburgh, Oslo, Stockholm, Copenhagen, Hamburg, Leipsig, Munchen and Paris. At Paris the tour terminated, some of the American physicians going to other sections of Europe on sight-seeing trips while others came back to their homes and work in the United States.

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Dr. E. E. Evenson, formerly of Antigo, has established his practice at Wittenberg, with office rooms above the Citizens State Bank building.

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"Points in Wisconsin's system of medical education will be adopted when we return to Cuba, and they will be applied to our specific needs," said Dr. Aristides Agramonte, professor of bacteriology at the University of Havana.

Dr. Agramonte, together with Dr. Salanos Ramos, dean of the Cuban medical school, and Felix Martin, professor of engineering and architecture, visited the University of Wisconsin medical school recently. They are members of a commission from the faculty of medicine and pharmacy from the Havana school which is investi-

gating American institutions, and are guests of the Rockefeller Foundation of New York.

The doctors were entertained at Maple Bluff country club at dinner by the faculty of the medical school. Sixty-four physicians attended, including, besides the faculty and the commission, Dr. S. J. Crumbine, executive secretary of the American Child Health association, New York; President Glenn Frank, and the faculties of the departments of physiological chemistry and agricultural chemistry and bacteriology.

Dr. Agramonte spoke on the study of medicine in Cuba, and told of the development of the University of Havana medical school, which was founded in 1728. He also described the work of the institution in combating disease on the island, and of its experiments on conditions there.

President Frank welcomed the visitors to the university, and Dean Bardeen of the medical school was toastmaster.

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Dr. C. E. McJilton has announced the opening of offices in the Smith block at River Falls. The doctor is a graduate of the University of Minnesota School of Medicine and has completed a fifteen months interneship in several hospitals of the twin cities. Previous to coming to River Falls he has been associated with the McIntyre Clinic at Virginia, Minn.

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Dr. F. D. Jackey, Thorp, retiring president of the Clark County Medical Society, suffered a stroke of paralysis recently. It is reported, however, that his condition is improving steadily.

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Announcement has been made by the hospital officials of the Methodist Hospital, Madison, affiliated with the Jackson Clinic, that the first unit of the new building will be dedicated September 15th and 16th. Approximately $750,000 has been expended in building, grounds and equipment to make this one of the most modern and complete structures of its kind. The central tower, above the seventh story, affords a beautiful view of Madison, its lakes and surrounding country. The initial unit will contain 125 beds and will comprise small wards, one- and two-bed rooms, and suites. One floor is devoted to obstetrical, two to medical, and the others to surgical cases. The operating floor contains two amphitheaters, two standard-sized operating rooms, special rooms for eye, ear, nose, throat and dental work, and space for x-ray and general laboratories. On this floor there are also living quarters for the house staff. On the ground floor is an emergency department with operating rooms and waiting rooms.

An invitation has been extended to the medical profession by Dr. R. H. Jackson, chief of staff, to inspect the hospital on Friday, September 16th. There will be a scientific and clinical program in the afternoon followed by a banquet in the evening.

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Dr. S. Plahner, Milwaukee, left recently for Europe to attend the Fourth International Congress for Individual Psychology at Vienna and to take up special work in internal medicine and neurology.

Dr. Gilbert E. Seaman, Milwaukee, has returned from Europe, where he attended the International Congress of Military Medicine at Warsaw, Poland, as a representative of the United States government and was also a guest of the British Medical Association at Edinburgh. He spent several months at the hospitals and clinics of Vienna, Paris and London and made a special study of social medicine in the several countries visited.

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Dr. C. C. Atherton, superintendent of the Wisconsin Memorial Hospital at Mendota, will return to his old position as superintendent of the Southern Wisconsin Colony and Training School at Union Grove as soon as a successor has been selected for the hospital position. Dr. Atherton was granted one year leave of absence from the training school owing to illness in his family. While on leave of absence he was requested by the State Board of Control to take over the superintendency of the Wisconsin Memorial Hospital and fill the unexpired term of Dr. R. L. Kenney, who resigned effective December 31, 1926, and whose term of office covered the period ending June 30, 1927. The doctor has now requested return to Union Grove and is remaining at Mendota at the request of the board until a successor has been appointed.

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"Health and its relation to rural and small community life" is the subject to be discussed in three sessions of the health section of the better communities conference to be held in Eau Claire, September 27th, 28th and 29th under the auspices of the Wisconsin Conference of Social Work.

Dr. W. D. Stovall, chief of the State Hygiene laboratory, will be in charge of the health section. A discussion of communicable disease control will be led by Dr. E. V. Brumbaugh, assistant health officer of Milwaukee, at the second meeting of the section. The third session will consider the problems of child and maternity health. Dr. Dorothy Mendenhall, Madison, a leader in child health work, will lead the discussion.

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Dr. W. G. Merrill of Wisconsin Rapids has been appointed commander of the Eighth Wisconsin District of the American Legion to succeed Marshall C. Graff of Wausau.

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Speaking on "How to get Sick", Dr. George E. Forkin, Menasha, gave members of the Rotary Club an interesting and amusing outline of things to do in urging nature to exert itself in the wrong direction, at a recent noon luncheon. Things that men do every day were contained in the list of suggestions offered by Dr. Forkin and he covered his subject from the period of the underfed baby to the overfed man in the "forties".

DEATHS

Dr. John Henry Voje, Oconomowoc, died Thursday, July 21st, at Columbia Hospital, Milwaukee, following an operation. He had been in declining health for some time.

The deceased was born in the year 1853 and was graduated from the Northwestern University Medical

School in 1876. He later studied at Vienna, Berlin and Leipsig. Dr. Voje was director of the Waldham Park Sanitarium at Oconomowoc, a member of the Waukesha County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. Surviving him are his wife, a son and a daughter.

CORRESPONDENCE

LOSS OF VISION

August 2, 1927.

Editor, Wisconsin Medical Journal,
Milwaukee, Wis.

My Dear Editor:

A few days ago it was my privilege to attend an open meeting held by the Wisconsin State Industrial Commission at the City Hall in Milwaukee City.

There were present besides the members of the Wisconsin Industrial Commission, about thirty individuals largely representative of Employers, Industrial Insurance Companys, and Oculists, who were invited to take active parts in the discussion of the matter of methods, rules, governing and scientific facts, etc., to be considered as applying in the determination of compensation to employees for loss of vision and loss of efficiency due to industrial disease or injuries to the eye.

I was very much interested in this. Particularly so as I feel that the development of this matter to its present or near present state of perfection is to some extent the ultimate result of efforts which I made by personal communications to the Wisconsin State Industrial Commission in the year of 1917, and also by a paper which I wrote, and read in October of that year before the American Academy of Ophthalmology and Oto-Laryngology at its Pittsburg annual meeting. This paper was published in the Wisconsin Medical Journal, Milwaukee, 1918, XVII, 54-61.

One of the great difficulties at that time was the attempt by those administering compensation awards to distort scientific facts to make them fit existing compensation laws.

A great deal of good work in the fields of lawmaking, common sense, and justice, has been done in the last ten years to the event that Wisconsin now has or will very soon have the most just, equable, and scientific common sense method of dealing with this problem that is possessed and practiced by any state in the union or in any government or community.

Very truly yours,

V. A. CHAPMAN.

SOCIETY RECORDS

New Members

Morgan, S. F., Kohler.

Thompson, A. S., Mt. Horeb.

Changes in Address

Erdlitz, F. J., Pestigo, to Battle Mountain San., Hot Springs, So. D.

Kusterman, A. F., Wauwatosa, to 1701 Wisconsin Ave., Milwaukee.

Steele, G. M., Oshkosh, to Box 184, Ripon.

Governor Zimmerman has signed the bill changing the "Mothers" pension law to one for "dependent children." In the old law where the phrase "mothers pensions" is used the new phrase will be substituted. The state prefers to have the policy one for the aid of children, rather than one for mothers. The benefits will be the same. The law merely places emphasis on the policy of aiding children.

* * *

Wisconsin now has a state narcotic law, designed after the federal statutes, concerning illegal traffic in drugs, Gov. Fred R. Zimmerman having signed the bill introduced by Senator Herbert H. Smith, Milwaukee, establishing such a law, enabling the state to prosecute in state courts, rather than in federal courts.

* * *

Semi-annual payment of city or village taxes without penalty for postponement is provided by a new Wisconsin law.

The former statutes permitted a municipality to postpone payment of a portion of taxes, not exceeding 50 per cent, but required that the tax-payer be charged interest of from 5 to 7 per cent upon the deferred amount.

Under provisions of a bill introduced by Assemblyman Gardner Withrow, La Crosse, passed by both houses, signed by the governor and now a law, cities may set their own interest upon such deferred payments, altogether abandoning the interest requirement if they desire.

* * *

C. W. Stoops, Platteville, newly appointed regent of the Wisconsin School of Mines, will succeed W. N. Smith, general manager of the Vinegar Hill Zinc company, whose term expired July 1 and who was not a candidate for reappointment. Mr. Stoops is one of the leading zinc mine operators of the field and active in public matters aside from his chosen occupation. The board as now composed is made up of State Superintendent John Callahan, John Beck, a prominent business man of Benton and C. W. Stoops.

* * *

Governor Zimmerman's appointment of Frank C. Klode, Milwaukee, to be a member of the state board of control, was confirmed by the senate with but two dissenting votes. He has assumed his duties. He succeeds Grant U. Haas, removed by the executive.

The governor named Antone Kuckuk, Shawano, former state senator, as a member of the annuity board to succeed C. E. Broughton, Sheboygan, who resigned recently.

* * *

A campaign for clean milk has been started by C. J. Kremer, state dairy and food commissioner. From now on "We Must Have Clean Milk," is a shibboleth that will be broadcast throughout the state, in the interests of better health.

Posters with that slogan and pictures of sediment made from clean milk, fair milk, dirty milk, and very dirty milk, have been prepared and sent to every milk receiving station, cheese factory, and butter factory in the state. These are being displayed in prominent places.

* * *

A commission of officers from the faculty of medicine and pharmacy of the University of Havana visited the University of Wisconsin early in August to study at first hand the work done here along these lines. This commission was composed of Dr. Salano Ramos, dean and professor of physiological chemistry, Dr. Carlos Finlay, professor of ophthalmology, Dr. Aristides Agramonte, professor of bacteriology, and Felix Martin, professor of engineering and architecture. This committee is making an extended study of medical school and hospital planning, building and organization.

The development of the university of medical school and hospital work and state-wide laboratory service has already aroused an interest extending far beyond the borders of the state. Recently a special commission from the medical school of Keio University, Tokyo, Japan, spent two days at Madison. This commission was composed of Dr. T. Kitashima, dean of the medical school, and Dr. Y. Kusama, professor of hygiene. The medical school of Keio University is considered the foremost in Japan. While these medical leaders from Japan were in Madison, the medical school and hospital were also visited by Dr. W. T. Sanger, president of the medical school of Virginia, Richmond.

* * *

The assembly sustained Gov. Zimmerman's veto of the Duncan beer bill and the senate killed the Polakowski bill for the complete repeal of the Severson Dry Law. Liquor laws remain as they were when the session convened, although the subject has been a bothersome one in the legislature.

* * *

A. D. Campbell, Madison, has been elected secretary of the state land commission to succeed Matt Lampert, deceased. Tester Bakken remains as assistant secretary.

* * *

Judge O. A. Stolen, who formerly presided over Dane county superior court, has been selected for the position of state humane agent to succeed A. E. Frederick, Sparta.

Stolen has been disbarred from the legal profession after his resignation from the bench because he borrowed money from bootleggers who appeared before him. The supreme court disbarred him for a period of five years. The appointment to this position is made by W. A. Duffy, Commissioner of Agriculture.

* * *

The first part of the state park extension program of the present session has become a reality with Gov. Fred R. Zimmerman signing the bill to purchase Copper Falls park in Ashland county, a tract of about 800 acres, at a cost of $1,700.

Copper Falls is one of the show places of the state with twin falls near together, one plunging 40 and the other 60 feet and joined at the base.

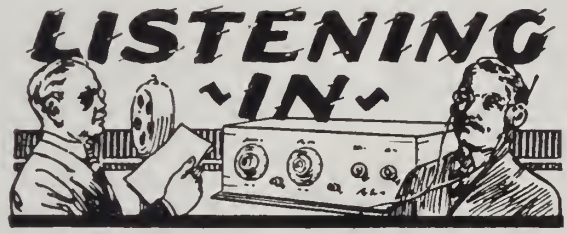
Copper Falls is on the Bad river and plunges over an escarpment of 60 feet. A few rods away, coming from another direction, is Tyler's falls.

The stream cut gorges between the two falls and below the juncture formed in post-glacier time, are deep sided. At places the gorge is 250 feet high and in the noon day the sunlight lights up the dark places in hues to red and green. Dense growths of trees are on the high embankments that hem in the roar of the waterfalls.

* * *

Wisconsin's new conservation commission has begun a series of sessions to lay the foundation for the new conservation policy of Wisconsin.

William Mauthe, Fond du Lac business man, is chairman of the new commission, and E. M. Dahlberg, Ladysmith, is its secretary. With the first meeting of the commission, Governor Zimmerman signed the appropriation bill for the commission providing $458,000 a year.



ETHICS

From time to time the Committee on Ethics of the State Society receives material which presents questions not easy of answer. Such a question was presented to the committee during July. In the present instance a professional announcement was being run in a paper some ninety miles from the office of those concerned. The committee felt that while there might be no violation of the Code in fact, there was serious question if there was not a violation in spirit.

It will be of interest to the members to know that since the press service of the society was established the Committee on Ethics has received less than two complaints a year in the field of public interviews.

A COMPENSATION QUESTION

In this instance an employe of a firm under the compensation act received a knee injury. She was cared for by the company physician for a period of three months at which time, feeling that her condition was growing worse, she employed another physician. No panel was tended her. The question subsequently arises whether the second physician is entitled to compensation for his services from the insurance company. In answering this question Chairman F. M. Wilcox of the Industrial Commission stated:

"If it can be established that there is failure on the part of the employer and the insurer to live up to the panel provisions of the statute, then Mrs. Blank is entitled to reimbursement for the fair value of the necessary and reasonable medical service rendered to her by Dr.

Delegates and Alternates Who Will Compose House of Delegates for Eighty-Sixth Anniversary Meeting at Eau Claire

SOCIETY	DELEGATES	ALTERNATES
Ashland-B-I	J. M. Dodd, Ashland	M. S. Hosmer, Ashland
Barron-P-W-S-B	D. L. Dawson, Rice Lake	J. A. Riegel, St. Croix Falls
Brown-Kewaunee	P. R. Minahan, Green Bay	E. S. Knox, Green Bay
Calumet	J. W. Goggins, Chilton	N. J. Knauf, Chilton
Chippewa	W. C. Henske, Chippewa Falls	H. H. Hurd, Chippewa Falls
Clark	S. G. Schwarz, Marshfield	F. P. Neis, Thorp
Columbia	A. F. Schmeling, Columbus	H. E. Gillette, Pardeeville
Crawford	A. J. McDowell, Soldiers Grove	T. E. Farrell, Seneca
Dane	W. T. Lindsay, Madison	E. S. Sullivan, Madison
	H. P. Greeley, Madison	H. M. Carter, Madison
Dodge	A. E. Bachhuber, Mayville	E. S. Elliott, Fox Lake
Door	F. C. Huff, Sturgeon Bay	E. J. Konop, Sawyer
Douglas	T. J. O'Leary, Superior	H. J. Orchard, Superior
Eau Claire & Associated Counties	H. M. Stang, Eau Claire	Frank E. Butler, Menomonie
	O. J. Blosmo, Menomonie	B. F. Johnson, Mondovi
Fond du Lac	S. E. Gavin, Fond du Lac	H. R. Sharpe, Fond du Lac
Grant	J. C. Betz, Boscobel	J. H. Fowler, Lancaster
Green	J. F. Mauermann, Monroe	W. G. Bear, Monroe
Green Lake-W-A	A. J. Wiesender, Berlin	W. E. Buckley, Red Granite
Iowa		
Jefferson	H. O. Caswell, Ft. Atkinson	J. F. Dennis, Waterloo
Juneau	C. C. Vogel, Elroy	
Kenosha	G. F. Adams, Kenosha	C. R. Caughey, Kenosha
La Crosse	W. E. Bannen, La Crosse	E. E. Gallagher
La Fayette		
Langlade	J. C. Wright, Antigo	J. W. Lambert, Antigo
Lincoln	W. H. Bayer, Merrill	E. K. Morris, Merrill
Manitowoc	F. E. Turgasen, Manitowoc	E. C. Cary, Reedsville
Marathon	J. M. Freeman, Wausau	A. W. Boslough, Wausau
Marinette-Florence	G. R. Duer, Marinette	J. V. May, Marinette
Milwaukee	S. G. Higgins, Wells Bldg	S. M. Mollinger, 396 11th Ave.
	J. O. Dieterle, 141 E. Wis	A. B. Schwartz, 418 E. North Ave.
	E. W. Miller, 217 Michigan	Herman Schumm, 141 E. Wis.
	R. W. Blumenthal, 123 Wis	D. E. W. Wenstrand, 733 Summit
	S. J. Seeger, Wells Bldg	C. J. Coffey, 221 Wisconsin Ave.
	H. J. Gramling, 1321 Forest Home	Oscar Lotz, Wells Bldg.
	H. W. Powers, 123 Wis. Ave	G. W. Neilson, 776 3d St.
	T. Willett, 625 72d Ave	E. F. Peterson, Wauwatosa
	M. F. MacRae, Wells Bldg	Bernard Krueger, Cudahy
	W. H. Halsey, 410 Jefferson St	J. H. Carroll, Wells Bldg.
	H. McCabe, 123 Wisconsin Ave	F. D. Murphy, 530 Wisconsin Ave.
	W. J. Egan, 141 E. Wisconsin	F. A. Thompson, 425 E Water
	W. M. Kearns, Straus Bldg	
Monroe	T. J. Sheehy, Tomah	J. M. Scantelton, Sparta
Oconto	E. A. Linger, Oconto	C. W. Stoelting, Oconto
Oneida-F-V	C. A. Richards, Rhinelander	
Outagamie	V. F. Marshall, Appleton	J. J. Laird, Black Creek
Pierce-St. Croix	J. W. Prentice, Amery	B. Kunny, Baldwin
Portage	H. M. Coon, Stevens Point	F. R. Krembs, Stevens Point
Price-Taylor	E. A. Riley, Park Falls	J. D. Leahy, Park Falls
Racine	Geo. W. Nott, Racine	H. B. Keland, Racine
Richland	J. S. Booher, Richland Center	George Parke, Viola
Rock	T. W. Nuzum, Janesville	P. A. Fox, Beloit
	W. A. Munn, Janesville	W. J. Allen, Beloit
Rusk	W. F. O'Connor, Ladysmith	R. C. Rodecker, Holcombe
Sauk	F. E. Tryon, Baraboo	W. J. Hummel, Ableman
Shawano	A. J. Gates, Tigerton	H. B. Norviel, Tigerton
Sheboygan	A. J. Knauf, Sheboygan	F. A. Nause, Sheboygan
Trempealeau-J-B	C. F. Peterson, Independence	H. A. Jegi, Galesville
Vernon	W. M. Trowbridge, Viroqua	W. H. Remer, Chaseburg
Walworth	E. J. Fucik, Williams Bay	M. V. DeWire, Sharon
Washington-Ozaukee	H. M. Lynch, Allenton	G. E. Savage, Port Washington
Waukesha	M. R. Wilkinson, Oconomowoc	F. C. Rogers, Oconomowoc
Waupaca	F. E. Chandler, Waupaca	T. E. Loope, Iola
Winnebago	J. W. Lockhart, Oshkosh	H. H. Meusel, Oshkosh
Wood	K. W. Doege, Marshfield	F. X. Pomainville, Wisconsin Rapids

Number Two. If Dr. Number Two's attendance upon Mrs. Blank was assumed by the insurance carrier as services performed for the company and the relationship between the company and the doctor an immediate one, then his remedy is not against Mrs. Blank, but against the company and jurisdiction over the matter is in the courts. If, however, the doctor's services were rendered at the instance of Mrs. Blank and because of failure on the part of the insurance company to attend her in compliance with law, then the proceeding is one upon the application of Mrs. Blank for reimbursement to the amount of her reasonable necessary expense. There is no claim that can be maintained by a physician against an employer or insurer under compensation. His action, if any, must be one directly against the employer and insurer. If there is no contract relationship between the doctor on one hand and the employer and insurer on the other, then the injured employe must meet her claim and claim reimbursement."

BOOK AGENTS

From time to time your secretary is offered five volumes of this or nine volumes of that if he will but endorse the publication. These requests divide themselves into two classes: Those where a "small payment" is required to "partially defray the cost" but which in fact more than pays for the cost, and (2) those where the endorsement is sought for the purpose of showing prospects what others think of the publication.

All such requests are promptly denied. No endorsements are ever issued from the secretary's office on any matter except proposals of the State Society or the American Medical Association. Beware of the man who claims society endorsement or endorsement of its officials for his project. If his offer is reputable it will be found in the advertising columns of the Journal.

YEARS OF WORK

When the writer finds himself discouraged because some pet idea fails of immediate accomplishment he reminds himself of the fact that it took six years to obtain the Wisconsin Basic Science law. If a project is based on right thinking, an early defeat does not mean that the thought is wrong.

The foregoing paragraph is prompted by comments from laymen in several parts of the state to the effect that physicians seem slow in promoting periodic health examinations. Contact with the laity, however, indicates that the demand is steadily growing and that the time is not far distant when the physician who fails to grasp the trend will fail to benefit from a great opportunity.

The movement for periodic examinations offers to the physician a new opportunity for a still closer relationship with the public that will accrue to the benefit of both. The growing demand assures its ultimate wide success.

Reservations Indicate Unusually Large Attendance for Eau Claire Meeting Sept. 20-23; Attractive Program and Entertainment Plans Assure Success

With three weeks left before the opening of the Eighty-sixth Annual Meeting of the State Medical Society of Wisconsin, every major plan for the scientific program and entertainment of the members and their wives at Eau Claire is completed. Hotel reservations are now being received and "no disappointments" is the promise of the host societies.

The meeting will unofficially open on Tuesday morning, September 20th, with the Biennial Conference of Health Officers of Wisconsin. At noon the annual golf tournament will be played and Tuesday evening will see the first meeting of the House of Delegates. The scientific sessions of the Society proper start on Wednesday morning, September 21st, and from then until late Friday evening the arrangements include meetings and entertainment of an almost continuous nature.

That the attractions of early autumn fishing and hunting in northern Wisconsin will not be overlooked is indicated by many letters from members in the southern part of the state who plan to spend the week-end before or after the meeting on some one of the countless nearby lake and river resorts. Tourist travel will be off the roads which

Randall Park

are now declared to be in excellent condition by the Highway Commission. That members may not be "tagged" for minor offenses involving local regulations, each member will receive a special poster for his car prior to the meeting. An additional supply will be available at the Registration booth.

A feature of the meeting will be the smoker for the members following the open session on Wednesday evening. A special committee in charge of this function refuse to disclose their

plans but assert that "sleep will be forgotten." A special three-day program has been arranged for the wives of the visiting members. Alumni of the medical schools will be given an opportunity to "reune" on Thursday noon. Luncheons have been arranged for graduates of Marquette, Rush, Chicago P. and S., and Northwestern. A general luncheon will be held for all other groups with special tables reserved by schools. The Marquette luncheon will be held at the Knights of Columbus Hall and the alumni of the other medical schools will have luncheon at the Hotel Eau Claire.

THE SCIENTIFIC PROGRAM

But finishing touches remain for the scientific program for both the meetings of the Health Officers and those of the State Society. The program to the hour of publication follows:

CONFERENCE OF HEALTH OFFICERS
Tuesday, September 20th

9:00 A. M. Registration.

10:00 A. M. Public Health, 1876-1926, Dr. C. A. Harper, State Health Officer.
Response, Dr. J. F. Farr, Health Officer, Eau Claire.

10:30 A. M. The A B C's of Public Health, Dr. W. D. Stovall, Director of Laboratories.

11:00 A. M. Wisconsin Maternity and Child Welfare Program, Dr. Cora S. Allen, Director of Bureau of Child Welfare.

11:15 A. M. Public Health Nursing, Miss Cornelia van Kooy, R. N.

11:30 A. M. General Discussion.

2:00 P. M. Protection of Public Water Supplies, Mr. C. M. Baker, State Sanitary Engineer.

2:15 P. M. Sanitation of Rural Homes, Mr. F. R. King, Domestic Sanitary Engineer.

2:30 P. M. Vital Statistics, Mr. L. W. Hutchcroft, Assistant State Health Officer.

2:45 P. M. Toxin Antitoxin, Dr. H. M. Guilford, Director of Bureau of Communicable Diseases.

3:00 P. M. Control of Rabies, Dr. G. W. Henika, Deputy State Health Officer.

3:15 P. M. Social Hygiene, Miss Aimee Zillmer, Lecturer in Social Hygiene.

3:30 P. M. Question Box and General Discussion.

Elks' Club where Smoker and Annual Dinner will be held

STATE MEDICAL SOCIETY

WEDNESDAY, SEPT. 21

9:00 A. M.—Public Health

1. Dr. S. J. Crumbine, General Executive, American Child Health Association of New York City—"A United Front for Child Health."
2. Dr. W. S. Leathers, Vanderbilt University, Nashville, Tenn.—"The Health Officer, Medical Profession and the Laity."
3. Dr. R. S. Dinsmore, Cleveland Clinic, Cleveland, Ohio —"The Practical Aspects of the Goiter Problem."

1:30 P. M.—Medicine

1. Dr. Robert B. Preble, Professor of Medicine, U. of Ill., Chicago—"Mistakes in Medicine."
2. Dr. Elsworth S. Smith, Clin. Prof. of Medicine, U. of Mo., St. Louis—"Cardio-Vascular Renal Diseases."
3. Dr. Peter Bassoe, Assoc. Prof. of Medicine, U. of Ill., Chicago—"The Origin, Rise and Decline of the Neurasthenia Concept."
4. Dr. W. C. Alvarez, Rochester, Minn.—"The Physiology of the Gastro-Intestinal Tract."

8:00 P. M.—Public Meeting, High School Auditorium

1. Address of Welcome, Dr. Geo. W. Beebe, President Eau Claire and Associated Counties Medical Society.
2. Dr. A. S. Loevenhart, Professor of Pharmacology, University of Wis.—"Patent Medicines."
3. President's Address—Dr. A. W. Rogers, Oconomowoc, President of the State Medical Society of Wisconsin.

THURSDAY, SEPT. 22

8:30 A. M.—Surgery

Symposium: The Aspects of Surgery in Industry.

1. Dr. S. J. Seeger, Milwaukee—"Burns."

Scene on Lake Hallie

2. Mr. L. A. Tarrell, formerly of the Industrial Commission of Wisconsin—"Estimation of Disability."
3. Dr. H. E. Mock, Chicago—"Physiotherapy and Industrial Surgery."

2:00 P. M.—Surgery

1. Dr. Reginald Jackson, Madison—"Acute Surgical Abdomen, Diagnosis and Treatment."
2. Dr. Wm. F. Braasch, Rochester, Minn.—"Calculi in the Uro-Genital Tract."
3. Dr. Arnold Schwyzer, St. Paul, Minn.—"Principles of Surgery of the Gall Bladder."
4. Dr. C. J. Combs, Oshkosh—"The Management of Common Fractures."

7:00 P. M.—Annual Dinner, Elks Club

FRIDAY, SEPT. 23

8:30 A. M.—General Medicine and Surgery

Symposium: Methods of Examination in General Practice

1. Orthopedics—Dr. F. J. Gaenslen, Milwaukee.
2. Neurology—Dr. Lewis J. Pollock, Ass't. Prof. of Neurology, Northwestern U., Chicago.

The Eau Claire Hotel, where all sessions of the House of Delegates will be held

3. Urology—Dr. Ira Sisk, U. of Wis., Madison.
4. Obstetrics—Dr. Carl Henry Davis, Milwaukee.
5. Pediatrics—Dr. Isaac A. Abt, Professor of Pediatrics, Northwestern U., Chicago.

1:30 P. M.

1. "Treatment of Pernicious Anemia"—Dr. Geo. R. Minot, Ass't. Professor of Medicine, Harvard Medical School, and Dr. Wm. P. Murphy, Ass't. Professor of Medicine, Harvard Medical School, Boston.
2. (To be announced later.)
3. Joint meeting with the Wisconsin Oto-Laryngological Society. Two papers by Dr. Geo. F. Suker of Chicago and Dr. Gordon Harkness of Davenport, Iowa. Subjects to be announced later.

GENERAL SYNOPSIS

For the convenience of the readers in planning attendance, a birdseye view of the meeting events follows:

Tuesday

8:00 A. M.—Exhibit Hall opens.
9:00 A. M.—Registration opens, State Medical Society and Biennial Conference of Health Officers, Fournier's Academy.
10:00 A. M.—First Session, Health Officers.
Noon—Golfers' Luncheon, Eau Claire Country Club. Followed by annual tournament play.
2:00 P. M.—Second Session, Health Officers.
4:30 P. M.—Council meeting, dinner, Hotel Eau Claire.
7:30 P. M.—First session, House of Delegates, Hotel Eau Claire.

Wednesday

8:00 A. M.—Exhibit Hall opens. Registration.
9:00 A. M.—First Scientific Session and Third Session, Health Officers, Academy.

Map showing Fournier's Academy, where scientific sessions will be held

Putnam Drive

Noon—Council luncheon, Hotel Eau Claire.
1:30 P. M.—Second Scientific Session, Academy.
6:40 P. M.—Second Session, House of Delegates, Hotel Eau Claire.
8:00 P. M.—Open meeting, High School Auditorium.
9:30 P. M.—Smoker for members, Elks' Club.

Thursday

8:00 A. M.—Exhibit Hall opens. Third Session, House of Delegates, Academy.
8:30 A. M.—Third Scientific Session, Academy.
Noon—Alumni luncheons.
2:00 P. M.—Fourth Scientific Session, Academy.
7:00 P. M.—Annual Dinner, Elks' Club.

Friday

8:00 A. M.—Exhibit Hall opens.
8:30 A. M.—Fifth Scientific Session.
Noon—Luncheon meeting, Radiological Section.
1:30 P. M.—Sixth Scientific Session.
6:00 P. M.—Dinner meeting, Oto-Laryngological Society.

ENTERTAINMENT FOR LADIES

Wives of visiting members will be the guests of wives of the members in Eau Claire, Chippewa and Dunn-Pepin counties for three days during the State Society meeting. As each member registers he will receive an envelope containing all announcements and invitations for the ladies. Entertainment to be given in their honor follows:

Wednesday

Noon—Luncheons at homes of Eau Claire ladies.
1:00 P. M.—Automobile drive to Menomonie for bridge and golf tournaments. Late luncheon at Menomonie.
Evening—Theatre party at Eau Claire.

Thursday

10:00 A. M.—Automobile drive around Eau Claire and vicinity.
Noon—Luncheon at Wissota Lake, Chippewa County, followed by trip on lake. Returning drive through Irvine Park, Chippewa Falls. Home in time for Annual Dinner.

Friday

Noon—Luncheon in Eau Claire. Bridge, special entertainment and late luncheon at Country Club.

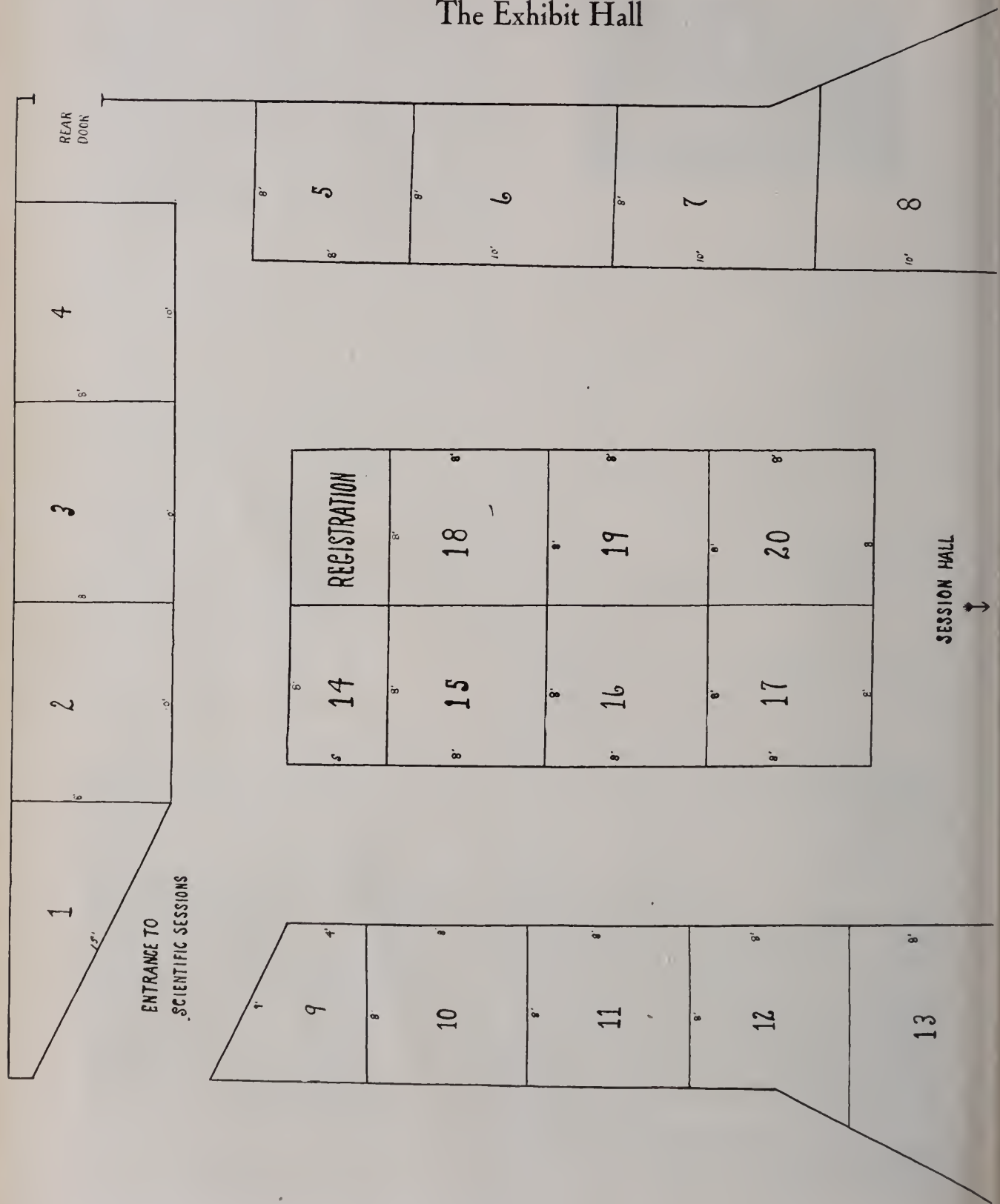
HOTEL RESERVATIONS

Your state society has reserved every available hotel room in Eau Claire. Each member planning to attend the meeting is urged to forward his reservation card or requests to Mr. Arthur Hedquist, Chamber of Commerce, Eau Claire, that each may have the facilities desired awaiting him at the minute of arrival.

"Eau Claire has accommodated 2,200. We can care for every one that attends this meeting and assure comfortable quarters, but mailing your requests now means that your room is ready for you the minute you arrive."

Academy where exhibits and scientific sessions will be held

The Exhibit Hall



COMMERCIAL-SCIENTIFIC EXHIBIT

Exhibitors at the Annual Meeting include the following:

1. Saunders Publishing Company, Philadelphia, Pa.
2. H. G. Fischer Co., Chicago and Milwaukee
3. Mellin's Food Company, Boston, Mass.
4. E. R. Squibb & Sons, New York City
5. DeShell Laboratories, Chicago
6. Horlick's Malted Milk Co., Racine
7. Roemer Drug Company, Milwaukee
8. Victor X-Ray Corp., Milwaukee and Chicago
9. E. H. Karrer Company, Milwaukee
10. Victor Mueller Company, Chicago
11. Physicians' and Hospitals' Supply Co., Minneapolis
12. N. P. Benson Optical Co., Minneapolis and Eau Claire
13. Pitman-Moore Co., Indianapolis
15. Pengelly X-Ray Company, Milwaukee and Minneapolis
16. Medical Protective Company of Fort Wayne, Ind.
17. Kremers-Urban Company, Milwaukee
18. Kelley-Koett Mfg. Co., Inc., Covington, Ky.
19. Abbott Laboratories, North Chicago
20. Hanovia Chemical & Mfg. Co., Newark, N. J.

Board of Health of Wisconsin, Madison

University of Wisconsin, Medical Package Library Service

Devine to Speak at Annual Dinner Thursday Evening

Edward T. Devine, Dean of the Graduate School and Professor of Social Economy of the American University, Washington, D. C., will be the sole speaker of the evening at the Annual Dinner to be given at the Elks' Club on Thursday evening. His subject will be announced in the final program.

Mr. Devine was secretary of the Charity Organization Society of New York for 21 years; he was associated with *Charities* and *The Survey*, either as editor or as associate editor, for 24 years; with the School of Philanthropy, either as director or as instructor, for 15 years; and for 14 years he was professor of Social Economy in Columbia University. Adding these figures together gives a total which suggest that by now he must be well over a hundred. But the date of his birth was 1867, and these seventy-odd years all fell between 1896 and 1921, the periods overlapping, with positions two, three, or four deep in most years.

He was born on a farm in Iowa; graduated from Cornell College in 1887; taught school in Iowa; studied at the University of Pennsylvania and the University of Halle; and in 1891 became staff lecturer, and later executive secretary, of the American Society for the Extension of University Teaching, with headquarters in Philadelphia. While in this position he lectured at the University of Edinburgh and gave courses at Oxford, as well as in many American communities.

In 1896 he came to New York to be secretary of the Charity Organization Society, and from that time on was a recognized leader in the rapidly developing social work of the country. Within a year he founded the periodical *Charities*, which developed into the journal known to-day as *The Survey*. A little later a summer training class was established, from which grew the New York School of Social Work. Tenement house reform, the prevention of tuberculosis, and other then novel activities were undertaken by the

At the Annual Dinner

society during his term of office, and were so quickly and widely adopted in other cities that they have already become familiar agencies in all parts of the country.

He was special representative of the American Red Cross in charge of relief in San Francisco after the great fire of 1906, and in Dayton, Ohio, after the floods of 1913. In 1916 he spent six months in Russia, as special agent of the American Embassy. During 1917-18 he was in charge of the Bureau of Relief and Refugees of the American Red Cross in France. He was president of the National Conference of Charities and Correction in 1906; president of the sociological section of the International Congress on Tuberculosis when it met in America for the first time, in 1908; one of the founders of the National Child Labor Committee and the National Tuberculosis Association; chairman of the Committee on Industrial Relations for the first months of its existence; and a member of the United States ("Fact-Finding") Coal Commission of 1922-23.

Among Mr. Devine's books are the following: Coal (1925); Social Work (1922); Disabled Soldiers and Sailors (1919); The Normal Life (1917); The Family and Social Work (1912); Misery and Its Causes (1909); The Principles of Relief (1904); the Practice of Charity (1901); Economics (1898). He has written hundreds of magazine articles, pamphlets, conference addresses, and other occasional papers.

State Medical Society Committees Offer Reports for Eighty-Sixth Anniversary Meeting at Eau Claire

REPORT OF COMMITTEE ON PUBLIC POLICY

As a preface to this report your committee reasserts its belief and position:

That it is the duty of the profession to provide accurate information from the viewpoint of medical science to those charged with the duty of law enactment and enforcement, but beyond that the responsibility for decision and choice lies with those elected by the people and responsible to them.

During the legislative session of 1927 your committee, working upon this basis, proposed a most comprehensive legislative program and takes natural pride in advising the society that of all bills the society was interested in as proponents, but three failed; one by senate action and two by vetoes of the governor. Further, of all the bills the society was interested in adversely, none were passed. There is attached to this report a list of some of the principal measures proposed during this session. Those in bold face type are measures proposed by the society by instructions of the 1926 House of Delegates.

Your committee takes this opportunity to impress upon each member of the society that our joint success is not alone due to our competent legislative counsel, Mr. Fred M. Wylie, nor to our secretary, who spent their time at the capitol. On the contrary, it is due to the assistance they received from individual members and county societies throughout the state whenever called upon. The problem of promoting legislation in the public health interest is largely the problem of informing members of the legislature. No one can do this better than the family physician. Continuation of such support insures success at all times.

RECOMMENDATIONS

Your committee makes the following recommendations for the consideration of the house:

1. That the following bills defeated at the 1927 session be introduced at the session of 1929:

a. A bill substituting a commission of physicians and the judge to determine questions of insanity in place of the lay jury; further, abolishing the present restriction upon the physician's commitment fee of four dollars for examination and ten cents for each mile of travel necessitated.

b. A bill providing that private institutions for the care of the mentally ill be licensed at their option and cost by the Board of Control, who shall inspect such licensed institutions annually.

c. A bill to provide sufficient funds for the purpose of driving from Wisconsin those who would prey upon the unfortunate sick, thus gaining their livelihood by quackery, fraud and deceit.

2. At the suggestion of the Board of Medical Examiners a measure was prepared for the 1927 session to prohibit what is now known as itinerant practitioners. Such practice has been termed by members of the Board of Medical Examiners as "abominable".

Just prior to the introduction of the bill, however, the board requested that it be withheld, declaring that they felt the itinerant could not be legally restrained; that such a law would only cause entanglements and at the same time cut them off from the $1,000 fee they were receiving.

Our legislative counsel, in whom we repose every confidence, assures us that itinerants can be restrained and that the legal entanglements resulting will be no greater than those envolved in any question of quackery. We do not believe that the fee received is of any material consideration and for the reason that we believe itinerant practice constitutes a health menace we recommend that a bill be introduced in the next session for the purpose of abolishing licensed itinerant practitioners of medicine and surgery in this state.

Respectfully submitted,

O. B. Bock, Chairman,
D. L. Dawson,
J. J. McGovern,
J. G. Crownhart, Secretary.

REPORT OF LEGISLATIVE ACTION

Bill No.	Proposal	Final Action
5-A.	Abolishing the old requirement that the Medical Examiners retain special legal counsel.	Vetoed by Governor
6-A.	Consolidating all examining boards under the direction of the State Board of Health. Bill introduced upon recommendation of the Interim Committee on Taxation.	Killed
68-A.	Providing a means for restoration of a license revoked by law. As the bill was originally drawn it would have presented ample opportunity to the unworthy. The State Society introduced a substitute which was adopted, making clear the intent that such restoration is only to apply in cases where an injustice has been done.	A law
88-A.	The legislative charter law for the state and county medical societies had not been changed since enactment in 1840. This was a bill to bring its provisions to date and enlarging the authority for society actions.	A law
151-A.	This bill proposed to establish a board of examiners in roentgenology, defined such practice and provided for a special license after examination for all who desired to practice in this field. The definition was so broad as to include every practicing physician in Wisconsin under its terms. Examination fee was $25; annual reregistration $5. The Board would also license lay technicians as experts. This measure would have committed a palpable fraud upon the public who would have considered licensed technicians to be specialists. It would have imposed heavy fees upon physicians. Following intensive survey these conclusions were reached by the committee, published in the Wisconsin Medical Journal, and the bill was opposed.	Killed
230-A.	This measure provided that persons convicted of a crime involving moral turpitude might, upon county authorization, be submitted to a medical examination. An amendment was adopted to exempt Christian Scientists.	Passed
239-A.	Under the law the Board of Medical Examiners is charged with the duty of investigating complaints of violations and instituting prosecutions. The Board found this might best be accomplished by employment of a lay investigator. Funds available, however, were very limited. This bill appropriated to the Board $5,000 annually for two years for law enforcement effort in the public interest. Passed by the Assembly 75-3; passed by Senate 23-10.	Vetoed by Governor
274-A.	Under the old law physicians who desired only to obtain alcohol for the purposes of sterilizing their instruments had to pay a $10 fee annually. This bill proposed fee exemption for the single purpose related.	A law
470-A.	This bill, introduced by the State Board of Health, was intended to strengthen certain statutes relating to quarantine. The Assembly adopted an amendment providing that chiropractors might treat cases of quarantinable diseases.	Killed
635-A.	A bill providing that the state health officer should have no outside practice, introduced in accordance with recommendation of the Governor.	Killed
11-S.	One provision of this measure restricted testimony of physicians in malpractice cases. This provision was—	Killed
102-S.	This was the Senate companion bill to 151-A.	Withdrawn
156-S.	A bill relating to commitment of the insane and providing (1) substitution of physicians as a commission to aid the judge instead of a lay jury, and (2) abolished the old restrictive fee of $4 for the physician called in cases to determine sanity substituting therefor a fee commensurate with the time and skill required as met approval of the judge concerned. This bill was fought by the Christian Scientists.	Vetoed by Governor

Bill No.	Proposal	Final Action
162-S.	Increasing the salary of the deputy state health officer.	Killed
168-S.	A general revision of the statutes relating to the licensing of physicians and surgeons, proposed by the Medical Board and State Society. Changes include (1) completion of intern year and first citizenship papers as pre-requisite to entering examinations; (2) provisions for checking on the credentials of foreign applicants; abolishing special legal counsel and bringing all sections to date.	A law
168-S.	An amendment proposed by Milwaukee County Medical Society would have abolished the requirements that of the seven physicians and surgeons on the medical board two must be eclectics, two homeopaths and three allopaths.	Killed
182-S.	This bill, fostered by the American Medical Association, provided that lye and like caustic preparations sold for household use should be labeled as poison and that the label should bear one antidote.	A law
251-S.	A departmental consolidation bill. As affects medical profession it was the same as 6-A.	Killed
281-S.	A bill introduced at the request of the Circuit Judges of the state to remove restrictions concerning so-called "privileged testimony" of physicians and to further restrict testimony of physicians sued for malpractice. At a conference between proponents and Society a substitute was adopted providing that physicians might testify in cases involving questions of homicide, insanity or malpractice without restriction; also, in certain cases where testimony was required to prove cause of death of patient where health or accident insurance is involved. Substitute bill was adopted.	A law
416-S.	Federal narcotic officials proposed an 18 page new state narcotic law. Provisions included several of a drastic nature affecting physicians; appointment of two state inspectors, and means of finance. Plan contemplated state permit fee for physicians. Society offered a substitute making needed amendments in old law and wiping out old provisions of drastic effect upon physicians. Society substitute adopted.	A law
505-S.	This measure provided that in cases involving emergency medical relief for the poor the chairman of the town or county, president of the village or mayor of the city might authorize financial expenditures required.	A law
550-S.	A bill by the Board of Control relating to commitment of the insane. Provisions included a revised questionnaire for commitment and provision for observation periods in certain cases.	A law
558-S.	A companion bill to 416-S providing for two state narcotic inspectors.	Killed
560-S.	Raising the fee from $4 to $10 for physicians and judges in cases involving commitment of the insane.	Killed
561-S.	Authorized private sanitariums for care of insane to accept public commitments at request and support of individual or family concerned and provided for their inspection and licensure by Board of Control upon own election and cost.	Killed

REPORT OF EDITORIAL BOARD

In so far as all receive a copy of the Journal every month—and we cherish the hope that your copy is given more than a passing glance—comments on the appearance, general make-up and contents seem unnecessary.

The cost of the Journal has now been brought down to seventy-five cents per member per year. A larger society membership, more and better advertising, with efficiency of the managing editor and his staff, have all been important factors active in the reduction of the cost. It may be of interest to note that this was the original cost of the Journal during the first days of publication—years ago.

Although your board has consistently held out for high standards in the matter of advertising admitted to the pages of the Journal, the lines have been drawn closer and closer, so that the member who turns to our advertising pages today has every possible assurance as to the integrity of the house and the quality of the product advertised. While such an advertising policy means an immediate loss to the Journal, we are confident that this policy will revert to the advantage of our members and will eventually mean a profit for our publication.

During the past year a number of original articles submitted to your board for publication had to be returned to the authors. We desire to call the attention of the members that the most common cause for rejection is not the lack of merit, but the length of the paper. Experience has shown that other things being equal, it is the short, snappy article that is most frequently read. Again a number of papers showing careful preparation and of real value were returned because the board felt that the subject matter was too highly specialized for a general publication such as our Journal.

Respectfully submitted,

EDITORIAL BOARD,
OSCAR LOTZ, Chairman.

COMMITTEE ON MEDICAL DEFENSE

We again come to you with a record of achievement that is worth your consideration. The following summary of the cases handled by your committee during this past year, and results attained, need no further analysis or comment:

1 Improper Treatment—will come to trial.
1 Faulty Diagnosis—will come to trial.
3 Fractures (3 cases)—dismissed.
1 Wrong Diagnosis—dismissed.
1 Infection—dismissed.
1 Improper Treatment—dismissed.
1 Fracture—non-suited.
1 Fracture—no suit begun.
1 Advice re claim—no suit begun.
1 Improper Treatment—no suit begun.

Total 12

The following tabulation gives a resumé of the total record of cases we have thus far been called upon to assist and defend:

Total, 1908 to date (August, 1927)	193	
Cases won	45	
Cases lost	8	
Cases pending	13	
Cases dismissed	38	
Many after trial and should rightly be added to those won.		
No action	76	
Many after attorney had filed replies.		
Refused	10	
4 members not in good standing; 3 not members of Society when alleged malpractice was committed; 3 not malpractice cases.	—	190

There is a discrepancy in these totals of 3; these were merely inquiries without further action being taken.

In view of the above successful record, I hardly see how there are those in the Society who still hold out and fail to take advantage of the opportunity here offered for legal services at a nominal cost.

Respectfully submitted,

ARTHUR J. PATEK, Secretary.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

In the last report of this committee a plan for establishing clinics for the examination of children of preschool age was outlined. This work was started in conjunction with the State Conference of Social Workers. During the last year one of these clinics has been started in a community in which there is not a full-time health officer and several other communities are now interested. The plan of operation is one of cooperation between local health organization, private or official, and the local medical profession.

In addition to this work the committee has taken part in a program for rural sanitation and communicable disease control. One member has prepared a budget which is considered to be the smallest amount upon which a health unit can function with any degree of effectiveness. This budget indicates the plan of organization of a small health unit and the amount necessary to maintain each branch of the work. Space will not permit the inclusion of this outline. It is important to say, however, that it suggests the use of a local physician as the chief executive officer for such a unit and therefore the health officer of the community.

LAY EDUCATION

Your committee reports that upwards of 200 daily and weekly newspapers of the state are now using the weekly press release of your State Society press service. Clippings indicate that the circulation of these articles reaches over a million readers each week and your committee feels that this service is of an importance that cannot be overestimated. The press service is edited under the direction of Mr. Fred L. Holmes of Madison, one of the most capable and prominent newspaper men of this state. To Mr. Holmes is due credit for the attractiveness of this service.

Members knowing editors that do not avail themselves of this free service can aid the committee by presenting the merits of this effort and calling attention of our State Secretary to the receptive fields.

The Society has continued its presentation of Hygeia to members of the legislature, state officials and promi-

nent laymen interested in the field of public health. Your Society now presents close to three hundred such subscriptions each Christmas Day.

Respectfully submitted,

W. D. Stovall, Chairman.

COMMITTEE ON MEDICAL EDUCATION

The Annual Congress of the A. M. A. on Medical Education, Medical Licensure, and Hospitals was held at the Palmer House, Chicago, February 14-16, 1927. Among the topics discussed which aroused special interest were (1) aims of medical education, (2) alteration of the present standardized curriculum, and (3) taking medical education to the practitioner.

Of these three general topics the first is the most fundamental. Methods can be intelligently discussed only when the results which the methods are intended to produce are kept in mind. Medical education is designed to train for the practice of medicine. The training, if it is to be effective, must be designed to prepare for the kind of service which the graduates will be called upon to render. The preliminary report of the Commission on Medical Education presented by the Director of Study, Dr. W. C. Rappleye, was notable because it stressed this point of view. This commission, composed of eighteen leaders in the field of general and medical education, public health work, and medical practice, with abundant funds at its disposal, contributed by the American Association of Medical Colleges, the American Medical Association, the Rockefeller Foundation, and the Carnegie Corporation, has begun its study of medical education with a survey of present conditions of medical practice and present trends of medical education and practice.

In a survey of demands for medical service conducted by means of a questionnaire it was shown that for 500 recent graduates practicing in communities of 50,000 or less, in 24 states and two provinces, out of 20,000 visits, 55 per cent were office visits, 35 per cent home visits, and 10 per cent hospital visits. Most illnesses are not difficult of diagnosis or treatment and 90 per cent can be cared for by a competently trained practitioner with modest equipment and facilities. About 75 per cent of the office work was for minor surgery, upper respiratory infections, and general medical and venereal diseases. About 90 per cent of the home visits were for infection of the respiratory tract, general medical and contagious diseases, obstetrics, and minor surgery. Of the hospital visits 55 per cent were for surgical, 30 per cent for medical, and 15 per cent for obstetrical conditions. Over 90 per cent of the illnesses are of types which cannot be controlled on a community basis but are problems of individual patients. Less than 10 per cent are diseases against which public health efforts are mainly directed. In most instances the physician is sought for the relief of symptoms, not for health advice. In the larger cities 20-25 per cent of the population who seek ambulatory medical attention receive it at organized charity clinics.

Recent graduates are locating in the cities and are going into the specialties in increasing proportion in response to economic "laws" and social conditions. At present the average age of physicians in small communities and rural districts is about 52 years. "Those of limited or moderate means in the small and rural communities are probably the least well supplied with medical services of any population group in the country." Any attempt to secure a more adequate distribution of practitioners to rural districts at the expense of proper preparation will eventually fail to meet the situation satisfactorily.

In spite of the recent trend toward special practice these studies show a great public demand for the kind of service which is best rendered by the well trained family practitioner. As the public learns to recognize the value of personal preventive medicine, such physicians will be called upon more and more to serve as personal health officers.

If the chief aim in medical education is to be to train physicians to meet the needs outlined, the chief defects in our present system of medical education appear to lie in (a) overcrowding of the schedule of work with highly specialized technical details, (b) lack of emphasis both in the preclinical and clinical work of broad fundamental principles, and (c) too impersonal an attitude toward the patients in teaching hospitals and clinics. President Ray Lyman Wilbur in a paper on altering the medical curriculum stressed the importance of making the student responsible for showing what he can do rather than for what he can reflect of verbal wisdom, and Dean Charles F. Martin again stressed the dangers of over-standardization and of letting material outweigh spiritual ideals. Dr. W. J. Mayo, Dr. Franklin C. McLean, Dr. Evarts Graham, and Dr. N. P. Colwell presented excellent papers in the main from the point of view outlined above. Dr. A. D. Bevan stressed the importance of better teaching of medical ethics, Dr. Walter S. Leathers that of teaching preventive medicine, and Dr. Frank B. Granger the teaching of physio-therapy.

Undergraduate medical education should have definite aims based on public needs and methods adapted to these aims, but medical education does not stop with undergraduate teaching. The university medical school must on the one hand support research in order to aid in medical progress and on the other hand make it possible for the practitioner to keep up with this progress. Dr. N. P. Colwell stressed the importance of hospitals, both those affiliated with medical schools and those not thus affiliated, in extending medical education to the practitioner. Dr. Walter L. Bierring gave a good paper on the teaching value of postgraduate clinics and clinical programs, Dr. Louis B. Wilson an excellent account of graduate medical education in Europe, and Dr. Charles A. Gordon gave a graphic description of the way in which medical education is being carried to the practitioner in New York State.

Medical education is making progress and it is making the greater progress because it is not hampered with smug self-satisfaction but, on the contrary, is stimulated by constant acute criticism. The present trend is away from standardization toward experimentation.

Respectfully submitted,

C. R. Bardeen,
L. F. Jermain,
E. Evans.

REPORT OF THE COMMITTEE ON NECROLOGY

It becomes the duty of your committee to report that during the year ending August 15th, 1927, the following physicians of Wisconsin have died. The names of those who were members of this Society are printed in bold face type:

Allen, Alva L. ..... Norwalk
Armitage, John E. ..... Kohler
Bachhuber, Louis M. ..... Mayville
Baker, John H. ..... Bryant
Becker, William F. ..... Wauwatosa
Broche, Arthur H. ..... Oshkosh
Brockway, Frank ..... Oshkosh
Brown, J. F. ..... Waupun
Buckmaster, Samuel B. ..... Delavan
Corbett, M. E. ..... Oshkosh
Fay, George H. ..... Whitewater
Fox, William E. ..... Milwaukee
Frew, James W. ..... Milwaukee
Fuson, Charles M. ..... Jump River
Geyer, Clarence W. ..... Milwaukee
Gregory, Daniel H. ..... De Pere
Halstead, Albert E. ..... Chicago, Ill.
Hollenbeck, Norman W. ..... Milwaukee
Jacobs, Edwin C. ..... Durand
John, Frederick F. ..... Milwaukee
Jones, Asa Norman ..... Reedsburg
Kappes, Paul J. ..... Milwaukee
Keller, Simon C. ..... Sauk City
Kelly, George F. ..... Milwaukee
Kingsley, James R. ..... Three Rivers, Mich.
Kreutzer, Alfred G. ..... Milwaukee
Lintleman, Fred R. ..... Janesville
Marquis, Arthur J. ..... De Pere
MacDougall, Peter ..... Waukau
McDougall, G. T. ..... Fond du Lac
McEachern, Walter A. ..... Superior
Meachem, John G. ..... Racine
Millard, Frank D. ..... Milwaukee
Moore, E. E. ..... Merrillan
Moulding, F. C. ..... Watertown
Olson, Chresten ..... Racine
Pember, J. F. ..... Janesville
Plumlee, Roscoe S. ..... Brooklyn
Pope, Francis J. ..... Racine
Potter, Jesse Y. ..... New London
Powell, John J. ..... Galesville
Pugh, George A. ..... Kenosha
Rehling, Charles F. ..... Fremont
Risher, Frank O. ..... Shell Lake
Roemheld, Frederick ..... Milwaukee
Rogers, E. H. ..... Stevens Point
Rouse, Harrison A. ..... Browntown
Sayles, L. W. ..... Baraboo
Schneider, Joseph ..... Milwaukee
Sears, Harry B. ..... Oshkosh
Sommers, Julius C. ..... Madison
Sorenson, Soren ..... Racine
Spencer, Leonard E. ..... Wausau
Strong, Warner B. ..... Milwaukee
Voje, John Henry ..... Oconomowoc
Welch, T. R. ..... Rhinelander
Weld, Henry Johnstone ..... Campbellsport
Whitney, D. C. ..... Rice Lake
Whyte, William Foote ..... Madison
Zilisch, Hubert E. ..... Milwaukee

Respectfully submitted,
THE COUNCIL,
J. G. CROWNHART, Secretary.

REPORT OF ADVISORY COMMITTEE ON HOSPITALS

There are in the United States at present a total of 6,896 hospitals of all types and kinds with 802,065 beds, constantly caring for an average of 629,362 patients.

The latest reports available show that there are in the state of Wisconsin 237 hospitals with a bed capacity of 24,666. Of this bed capacity 12,772 are available for general use. Only a little over one-half of this number are actually in use, but the overhead cost of the unoccupied beds continue. This great discrepency between the number of beds available and the number actually in use should be reduced, thereby reducing the cost of hospitalization to the patient without reducing the service rendered. There are available 9,894 beds for nervous and mental cases; 1,625 beds for tuberculosis and 375 beds for miscellaneous purposes. The beds available for tuberculous and nervous and mental cases are much more nearly filled than those in any of the groups.

Of the 237 hospitals in the state 6 are under federal, 17 under state, 54 under county, 12 under city, and 148 under private, association and religious order control.

Of the 237 hospitals in the state only 19 are approved for interneships by the American College of Surgeons. These hospitals offer 90 appointments. Nine of these hospitals offer 31 resident appointments in the specialties.

In Wisconsin the following counties have no hospitals for community use: Adams, Clark, Florence, Green Lake, Iron, Jackson, Kewaunee, Marquette, Vilas, Washburn, and Waushara.

Respectfully submitted,
R. C. BUERKI, for the Committee.

REPORT OF CHAIRMAN OF THE COUNCIL

Your chairman desires to emphasize two important points in this report: (1) the growing responsibilities of the councilor, and (2) the work during the past year.

With the adoption of the new constitution a year ago the council now stands in the position of the house of delegates at all times when the house is not in session. It is the unwritten policy of the council, however, to avoid from inaugurating new policies of the society when such questions may be deferred for future further action by the house of delegates. Nevertheless emergencies arise and your council of today may be called upon to formulate policies or do those things which commit the society to a course of action.

The individual councilor has long graduated from the position of peace-maker for his district. With common purposes worthy of united action and an understanding of those purposes that is now general throughout the state, the difficulties that used to present themselves to

the councilor in the form of factional politics are now rarely found. In place of the duties as peace-maker we find the position of councilor one that entails far greater responsibilities. He is one of twelve men that compose the body whose responsibilities have been outlined above. Even more, he is responsible to our State Society for the individual well-being and the community growth of each of the county societies within his jurisdiction. Is a county society falling by the wayside—his is the responsibility. Is a district meeting forgotten—his is the responsibility. Is a society out of touch with the field of effort of the state organization—his is the responsibility.

All this I set forth that delegates and members alike may be reminded that above all officers, your councilor is the one position which must not be filled to confer an honor upon an individual. It is an office that confers an honor only in proportion to the work well done.

During the year past your council has taken the following actions:

1. Re-elected George Crownhart as secretary of the society for the year expiring January, 1928, and Dr. Rock Sleyster as treasurer, same term.

2. Elected as a committee on auditing and finance, Drs. J. M. Dodd, Ashland; Arthur W. Rogers, Oconomowoc, and C. A. Harper, Madison.

3. Empowered the treasurer and secretary to remit the current dues of a member upon recommendation of his county secretary for reason of ill health causing financial hardships.

4. Authorized the publication and reprinting of a leaflet by the State Board of Health on the subject of periodic health examinations. This reprint is now available from the State Society for lay distribution.

5. Authorized a session held in Milwaukee in the late spring for the instruction of speakers in the field of periodic health examination, such speakers available for county medical societies.

6. Refused to appropriate society funds to the State Board of Medical Examiners for the purposes of law enforcement. See Wisconsin Medical Journal, February 1, 1927, pages 109, 110, 111, 112, 115, 116, 117, 118.

It is of more than passing interest to note that with the continuation and broadening of our lay educational campaign, particularly the service to the press, your council committee on ethics has found that the former offensive newspaper interviews of an unethical nature have almost entirely disappeared.

The councilor district meetings inaugurated throughout the state a year ago have been of uniform success. Their continuance and ever-increasing value is now assured. To this end your council promises its best efforts both as a group and as individuals.

Respectfully submitted,

EDWARD EVANS,
Chairman of the Council.

TREASURER'S REPORT

July 31, 1927.

RECEIPTS

1926		General Fund	Medical Defense Fund	Balance
Aug.	1—Balance cash in bank	$4,628.61	$3,409.63	$8,038.24
Aug.	5—J. G. Crownhart, Sec'y	269.00	24.00	
Sep.	3—J. G. Crownhart, Sec'y	129.75	16.00	
Sep.	3—Hanovia Chemical Co.	42.50		
Sep.	3—Frank S. Betz & Co.	25.00		
Sep.	10—Mellin's Food Co.	67.50		
Sep.	10—Paul B. Hoeber	37.50		
Sep.	20—Sale of Annual Dinner Tickets	947.50		
Sep.	20—Kalak Co.	50.00		
Sep.	20—Cameron's Surg. Specialty Co.	37.50		
Sep.	20—Merrell-Soule Co.	120.00		
Sep.	20—Horlick's Malted Milk Co.	40.00		
Sep.	20—Sharp & Smith	65.00		
Sep.	22—Kremers-Urban Co.	75.00		
Sep.	22—Physicians & Hospitals Sup. Co.	120.00		
Sep.	22—Scanlan-Morris Co.	135.00		
Sep.	22—Paul B. Hoeber	37.50		
Sep.	22—Roemer Drug Co.	75.00		
Sep.	30—H. E. Pengelly	12.97		
Sep.	30—Pengelly X-ray Co.	80.00		
Sep.	30—Victor X-ray Co.	62.50		
Sep.	30—Medical Protective Co.	90.00		
Oct.	4—J. G. Crownhart, Sec'y	115.00	16.00	
Oct.	4—E. R. Squibb & Co.	75.00		
Oct.	25—Abbott Laboratories	75.00		
Oct.	25—Victor Mueller	75.00		
Oct.	25—Spencer Lens Co.	50.00		
Oct.	25—Pitman-Moore	85.00		
Oct.	25—Saunders Co.	120.00		
Oct.	27—J. G. Crownhart, Sec'y	194.25	42.00	
Nov.	16—Interest Earned on Bonds	180.00		
Nov.	20—J. G. Crownhart, Sec'y	17.12		
Nov.	20—Kelly-Koett Co.	75.00		
Dec.	2—J. G. Crownhart, Sec'y	119.00	30.00	
Dec.	6—Wisconsin Telephone Co., Refund	2.85		

1927			
Jan. 3—J. G. Crownhart, Sec'y	36.00		
Jan. 3—J. G. Crownhart, Sec'y	1,170.00	162.00	
Jan. 20—J. G. Crownhart, Sec'y	3,500.00		
Jan. 25—Interest on Bonds	240.00		
Feb. 2—J. G. Crownhart, Sec'y	2,504.25	738.00	
Mar. 1—J. G. Crownhart, Sec'y	4,570.00	634.00	
Apr. 1—J. G. Crownhart, Sec'y	4,079.00	502.00	
Apr. 1—J. G. Crownhart, Sec'y, Ex. Space	150.00		
Apr. 25—Interest on Bonds	180.00		
Apr. 25—Fischer & Co.	59.50		
May 2—J. G. Crownhart, Sec'y	2,090.00	265.00	
May 31—Pengelly—Exhibit Space	50.00		
May 31—DeShell—Exhibit Space	50.00		
May 31—Hanovia Chemical Co.	55.00		
May 31—Mellin's Food Co.	50.00		
May 31—Victor Mueller	50.00		
May 31—Saunders Co.	60.00		
May 31—Horlick's Malted Milk Co.	40.00		
May 31—Pitman-Moore Co.	50.00		
June 1—J. G. Crownhart, Sec'y	1,103.50	150.00	
June 23—E. R. Squibb & Co.	80.00		
June 23—Victor X-ray Corporation	45.00		
July 1—J. G. Crownhart, Sec'y	510.00	68.00	
July 26—Interest on Bonds	240.00		
July 31—J. G. Crownhart, Sec'y	564.25	70.00	27,945.94
	$25,228.94	$2,717.00	$35,984.18

DISBURSEMENTS

	General Fund	Medical Defense Fund	Balance
Forward			$35,984.18
1926			
Aug. 1—J. G. Crownhart, Sec'y	$ 366.66		
Aug. 1—Florence Ripley	117.50		
Aug. 1—Astrid Jurgens	110.00		
Aug. 1—Fred L. Holmes	150.00		
Aug. 1—Timothy Egan	25.00		
Aug. 5—Wisconsin Medical Journal	38.75		
Aug. 5—J. G. Crownhart, Sec'y	155.30		
Aug. 25—J. G. Crownhart, Sec'y	100.00		
Aug. 25—Brd. of Trustees, 1st Cong. Church	25.00		
Sep. 2—Cannon Printing Co.	232.00		
Sep. 2—Fred L. Holmes	150.00		
Sep. 2—Dr. O. B. Bock	50.00		
Sep. 2—Dr. Spencer Beebe	41.65		
Sep. 2—Dr. Wm. J. Egan	14.90		
Sep. 2—Dr. F. J. Gaenslen	13.70		
Sep. 2—Dr. D. L. Dawson	29.99		
Sep. 2—J. G. Crownhart, Sec'y	366.66		
Sep. 2—Florence Ripley	94.00		
Sep. 2—Astrid Jurgens	110.00		
Sep. 2—Cannon Printing Co.	347.50		
Sep. 2—Wisconsin Medical Journal	21.25		
Sep. 2—J. G. Crownhart, Sec'y	112.33		
Sep. 2—Jack's Letter Service	14.50		
Sep. 3—Wisconsin Telephone Co.	34.57		
Sep. 3—Medical Arts Building	96.00		
Sep. 10—Cannon Printing Co.	120.00		
Sep. 10—F. H. Noble & Co.	162.00		
Sep. 10—J. G. Crownhart	100.00		
Sep. 16—Dr. Curran Pope	50.00		
Sep. 17—Madison Tent & Awning Co.	27.50		
Sep. 17—"Mac Did It" Sign Co.	112.50		
Sep. 18—W. F. Brown	30.00		
Sep. 18—Hotel Loraine	983.59		
Sep. 18—Geo. J. Fessler	398.00		
Sep. 18—Dr. Jos. F. Smith	13.00		
Sep. 18—Cannon Printing Co.	116.50		
Sep. 22—Astrid Jurgens	49.18		
Sep. 26—G. Felsenthal & Sons	43.10		
Sep. 26—Dr. A. G. Young	54.50		
Sep. 26—Guy Martin	79.90		
Sep. 26—Dr. W. J. MacDonald	63.00		

Sep.	26—Dr. Bernard Fantus	25.00
Sep.	30—J. G. Crownhart, Sec'y	366.66
Sep.	30—Florence Ripley	94.00
Sep.	30—Astrid Jurgens	110.00
Oct.	5—Milw. Academy of Medicine	48.00
Oct.	5—Wisconsin Medical Journal	20.00
Oct.	5—J. G. Crownhart, Sec'y	487.80
Oct.	5—J. G. Crownhart, Sec'y	264.64
Nov.	1—J. G. Crownhart, Sec'y	366.66
Nov.	1—Florence Ripley	117.50
Nov.	1—Astrid Jurgens	110.00
Nov.	1—Fred L. Holmes	300.00
Nov.	1—Milw. Academy of Medicine	48.00
Nov.	1—Wisconsin Medical Journal	33.75
Nov.	1—Cannon Printing Co	18.50
Nov.	16—Wisconsin Telephone Co	14.96
Nov.	29—Cannon Printing Co	27.50
Nov.	29—Fred Holmes	150.00
Nov.	29—J. G. Crownhart, Sec'y	366.66
Nov.	29—Florence Ripley	94.00
Nov.	29—Astrid Jurgens	110.00
Dec.	6—Wisconsin Medical Journal	26.25
Dec.	6—Master Reporting Co	432.11
Dec.	6—Cannon Printing Co	28.50
Dec.	20—Milwaukee Academy of Medicine	48.00
Dec.	21—Lincoln Fireproof Warehouse	24.10
Dec.	21—Florence Ripley	117.50
Dec.	21—Astrid Jurgens	110.00
1927		
Jan.	3—J. G. Crownhart, Sec'y	366.66
Jan.	3—J. G. Crownhart, Sec'y	235.56
Jan.	3—Wisconsin Medical Journal	5.00
Jan.	3—Employers Mutual Liability	9.00
Jan.	3—Fred L. Holmes	150.00
Jan.	7—Cannon Printing Co	336.00
Jan.	7—Wisconsin Telephone Co	13.71
Jan.	7—Milwaukee Academy of Medicine	48.00
Jan.	7—O. N. Nelson & Son	32.50
Jan.	8—Dr. F. R. Krembs	7.97
Jan.	8—Dr. H. A. Schulz	6.00
Jan.	8—Dr. Carl D. Neidhold	8.00
Jan.	8—Dr. Thos. P. Keenan	5.00
Jan.	8—Dr. Susan Jones	1.00
Jan.	8—Dr. W. C. Henske	20.00
Jan.	8—Dr. H. E. Gillette	3.25
Jan.	8—Dr. H. A. Birmie	1.25
Jan.	8—Dr. R. L. MacCornack	12.50
Jan.	8—Dr. H. M. Stang	18.00
Jan.	8—Dr. R. H. Bitter	3.88
Jan.	8—Dr. G. J. Juckem	2.90
Jan.	8—Dr. E. A. Armstrong	10.00
Jan.	8—Dr. J. W. Prentice	22.75
Jan.	8—Dr. A. C. Nickels	1.60
Jan.	8—Dr. N. P. Anderson	17.50
Jan.	8—Dr. H. C. Johnson	12.00
Jan.	8—Dr. J. D. Leahy	21.60
Jan.	8—Dr. R. McE. Schauffler, K. C.	65.00
Jan.	8—Dr. M. P. Andrews	7.50
Jan.	8—Dr. G. K. Wooll	5.12
Jan.	8—Dr. H. E. Kasten	8.00
Jan.	8—Dr. J. F. Mauermann	15.78
Jan.	8—Dr. H. Reese	3.63
Jan.	8—Dr. C. E. Stubenwoll	7.00
Jan.	20—F. M. Wylie	500.00
Jan.	20—Quarles, Spence & Quarles	25.00
Jan.	20—University Club	122.05
Jan.	20—Siekert & Baum Stationery Co	12.05
Jan.	20—Dr. A. M. Christofferson	5.00
Jan.	20—Dr. J. F. Wilkinson	1.18
Jan.	20—Dr. S. A. Ennis	11.00
Jan.	24—Myrtle E. Galvin	90.00
Feb.	1—Wisconsin Medical Journal	300.00
Feb.	1—Geo. J. Crownhart, Sec'y	400.00
Feb.	1—Florence Ripley	104.00
Feb.	1—Astrid Jurgens	120.00
Feb.	1—Geo. J. Crownhart, Sec'y	186.34

Feb.	1—Fred L. Holmes	175.00	
Feb.	1—Cannon Printing Co.	78.50	
Feb.	1—Fox Insurance Agency	12.50	
Feb.	19—Milwaukee Academy of Medicine	48.00	
Feb.	19—American Medical Association	442.50	
Feb.	19—Cannon Printing Co.	33.00	
Mar.	1—J. G. Crownhart, Sec'y	400.00	
Mar.	1—Florence Ripley	104.00	
Mar.	1—Astrid Jurgens	120.00	
Mar.	1—Wisconsin Medical Journal	150.00	
Mar.	1—J. G. Crownhart, Sec'y	248.43	
Mar.	1—Fred L. Holmes	175.00	
Mar.	9—Wisconsin Telephone Co.	19.78	
Mar.	9—Milwaukee Academy of Medicine	48.00	
Mar.	9—Western Union Telegraph Co.	11.14	
Mar.	9—Siekert & Baum Stationery Co.	14.90	
Mar.	16—University Club	21.93	
Mar.	16—Cannon Printing Co.	83.00	
Mar.	16—Wisconsin Medical Journal	50.00	
Mar.	30—Dr. C. B. Hatleberg	26.60	
Mar.	30—J. G. Crownhart, Sec'y	400.00	
Mar.	30—Florence Ripley	130.00	
Mar.	30—Astrid Jurgens	120.00	
Mar.	30—Fred L. Holmes	175.00	
Mar.	30—Dr. Nels Werner	27.00	
Mar.	30—Dr. H. M. Stang	49.00	
Mar.	30—Cannon Printing Co.	106.00	
Mar.	30—J. G. Crownhart, Sec'y	171.36	
Apr.	8—Wisconsin Medical Journal	150.00	
Apr.	8—Milwaukee Academy of Medicine	48.00	
Apr.	8—Western Union Telegraph Co.	14.02	
Apr.	8—Lines, Spooner & Quarles		1,796.25
Apr.	9—Wisconsin Telephone Co.	31.07	
Apr.	23—Fred M. Wylie	500.00	
Apr.	30—J. G. Crownhart, Sec'y	147.59	
Apr.	30—J. G. Crownhart, Sec'y	400.00	
Apr.	30—Florence Ripley	104.00	
Apr.	30—Astrid Jurgens	120.00	
May	10—Wisconsin Medical Journal	150.00	
May	10—Fred L. Holmes	175.00	
May	10—Milwaukee Academy of Medicine	48.00	
May	10—Wisconsin Printing Co.	193.00	
May	23—E. E. Brossard	10.00	
May	23—Wisconsin Printing Co.	139.75	
May	23—John C. Becker Co.	11.75	
May	23—H. H. West & Co.	27.50	
May	27—J. G. Crownhart, Sec'y	400.00	
May	27—Astrid Jurgens	120.00	
May	27—Florence Ripley	104.00	
May	31—Fred L. Holmes	175.00	
May	31—Wisconsin Printing Co.	23.25	
May	31—J. G. Crownhart, Sec'y	189.13	
May	31—Dr. Jos. F. Smith	93.45	
May	31—Dr. John M. Dodd	87.17	
June	1—Wisconsin Medical Journal	150.00	
June	1—Academy of Medicine	48.00	
June	21—J. G. Crownhart, Sec'y	100.00	
June	23—Wisconsin Telephone Co.	33.90	
June	23—Wisconsin Printing Co.	136.00	
June	23—Kelox Mnfg. Co.	10.00	
June	23—Dr. T. J. Hambley	11.00	
June	23—Hon. C. B. Ballard	21.50	
June	28—Fred L. Holmes	175.00	
June	28—M. E. Gordon Exhibit Co.	450.00	
June	30—Wisconsin Medical Journal	150.00	
June	30—J. G. Crownhart, Sec'y	266.27	
June	30—J. G. Crownhart, Sec'y	400.00	
June	30—Florence Ripley	130.00	
June	30—Astrid Jurgens	120.00	
July	11—Milwaukee Academy of Medicine	48.00	
July	22—Wisconsin Telephone Co.	20.09	
July	22—H. M. Stang	40.44	
July	30—J. G. Crownhart, Sec'y	400.00	
July	30—Florence Ripley	104.00	
July	30—Astrid Jurgens	120.00	
July	30—Wisconsin Medical Journal	150.00	

July 30—J. G. Crownhart, Sec'y	120.68		
July 30—Ralph Podlinshek	25.00		
July 30—Wisconsin Printing Co	189.23		
Total Disbursements	$22,861.83	$1,796.25	$24,658.08
Bank Balance, July 31, 1927			$11,326.10

SUMMARY

Covering Period from August 1, 1926, to July 31, 1927.

GENERAL FUND		
Balance August 1, 1926	$ 4,628.61	
Total Receipts to July 31, 1927	25,228.94	
	$29,857.55	
Disbursements	22,861.83	
BALANCE General Fund		$ 6,995.72
MEDICAL DEFENSE FUND		
Balance August 1, 1926	$ 3,409.63	
Total Receipts to July 31, 1927	2,717.00	
	$ 6,126.63	
Disbursements	1,796.25	
Balance Medical Defense		4,330.38
Total Funds as per Bank Balance		$11,326.10

SUMMARY OF FINANCES AS OF JULY 31, 1927.

General Fund	$ 6,995.72
Medical Defense Fund	4,330.38
Securities, as per attached list	18,000.00
Petty Cash in hands of Secretary	400.00
TOTAL Cash Assets of the Society July 31, 1927	$29,726.10

INVESTMENT SECURITIES

BONDS	Due	Rate	Amount
Northern States Power Co	1941	5%	$ 500 00
Northern States Power Co	1941	5%	500.00
Northern States Power Co	1941	5%	500.00
Northern States Power Co	1941	5%	500.00
Northern States Power Co	1941	5%	500.00
Northern States Power Co	1941	5%	500.00
Northern States Power Co	1941	5%	500.00
Northern States Power Co	1941	5%	500.00
The Milwaukee Electric Railway & Light Co	1931	4½%	2,000.00
The Milwaukee Electric Railway & Light Co	1931	4½%	2,000.00
American Telephone & Telegraph Co	1936	4%	4,000.00
Wisconsin Traction, Light, Heat & Power Co	1931	5%	1,000.00
Wisconsin Traction, Light, Heat & Power Co	1931	5%	1,000.00
Wisconsin Traction, Light, Heat & Power Co	1931	5%	1,000.00
Wisconsin Public Service Co	1942	5%	3,000.00
			$18,000.00

Respectfully submitted,

ROCK SLEYSTER,
Treasurer.

REPORT OF THE SECRETARY-EDITOR

That this report may be concise it treats separately each of the four fields of work of your executive officer.

SECRETARIAL DUTIES

On August 15th the membership was 2004 as compared to 1993 at the same time a year ago. It is to be noted that the increase in dues from $9 to $10, effective this year, has not affected the membership rolls. It is gratifying to report that for 1927 slightly over 71 per cent of the members are availing themselves of the medical defense offered by the Society as compared to an average of 55 per cent during recent years.

Since the last annual meeting the plan of councilor district meetings at least once a year has reached attainment. An excellent series of meetings was completed late in 1926 and the series for the current year has been of such success as to promise their continuance. Such meetings offer a very real opportunity for the larger development of Wisconsin medicine and their value to the membership may be further enhanced each year by carefully planned programs.

During the current year, plans for a greater usefulness of facilities available to the profession through the Extension Division of the University of Wisconsin have been adopted. These have been fully set forth in the Journal and may be summarized under four divisions establishing funds for (1) the furnishing of selected speakers for medical meetings, (2) the enlargement of the packet and book library service, (3) inaugurating short post graduate courses at the Medical School effective for the summer of 1928, and (4) inaugurating intensive field post graduate instruction effective in the spring of 1928. For the biennial 1927-28 and 1928-29 the annual appropriation available and to be expended in these enumerated fields is $7,500.

The time is past when the State Medical Society of Wisconsin should have component societies of a "paper" nature. Each society, no matter where located, has available to it speakers from the Extension Division and such men are obtainable without cost to the society. This, in addition to material available from within the county and from adjoining counties, together with Councilor visits, offers the opportunity for at least a few excellent meetings each year in each society. The strength of the state organization is wholly dependent upon the strength of its component societies. The coming year may well see major attention devoted to the further building and strengthening of the county societies. This thought is offered in no spirit of criticism, for the past has seen many societies greatly hampered in their work because of location and lack of funds. With these barriers effectively removed the small and inadvantageously located societies may now offer meetings of a type found in the larger centers.

While the legislative session lasting over seven months has made great demands upon the time of your Secretary, he has found it possible to personally attend the following meetings: Tenth Councilor District (2), Eleventh Councilor District, Fourth Councilor District (2), First Councilor District, Fifth Councilor District, Pierce-St. Croix, Rock, Langlade, Jefferson, Dane, Ashland-Bayfield-Iron, and Racine. These visits serve not only to acquaint members with the activities of the Society, but also to give the Secretary an opportunity to ascertain the needs of the membership.

During last January, by authorization of the 1926 House of Delegates, a conference was held in Milwaukee of county secretaries and councilors. Thirty-six of fifty secretaries were present for the meeting. The value of such an annual meeting to the organization cannot be over-estimated. It presents a round-table discussion of group problems with the resultant interchange of ideas for the betterment of the component units. Such conferences may well be continued annually.

THE JOURNAL

In view of the report of the Chairman of the Editorial Board, little need be said with respect to the Wisconsin Medical Journal. The cost to the Society continues to grow less despite the fact that every effort is made to present the most valuable and attractive material possible. Attention is called to the value of certain special articles published during the past year dealing with professional, though not scientific, problems. This series will be continued in the future.

SERVICE TO THE MEMBERS

This growing field of activity of your State Society now offers a value to the membership that pays handsome dividends upon the annual dues. In the field of legislation during 1927 attention of the members is especially called to the following bills, full report of which will be found in the report of the Committee on Public Policy:

a. Under a bill on physician's testimony proposed restrictions in malpractice cases were defeated and an old unjust provision eliminated.

b. A measure proposing a new license and annual reregistration fees of $25 and $5 respectively, affecting all physicians, was defeated.

c. Phraseology of the old state narcotic law that could be held over the head of any physician as a club upon a demand for his permit, was repealed.. New subject matter of a like character was defeated.

d. A bill was passed whereby the physician can obtain the authority of one official for treatment of the poor rather than rendering the treatment and then having the bill denied because it was not authorized at a formal board or council session before the treatment was given.

Along somewhat similar line was the obtaining of a ruling permitting physicians to make certain tax reductions upon snowmobile depreciation not heretofore permitted. Investigations into the cause of malpractice cases continued with the result that means are being found to prevent the origin of the fraudulent type.

A special number of the Journal was issued setting forth in a concise manner the application of tax and other laws to the profession. Through the columns of the Journal and the Secretary's office, over twenty members have either disposed of their practice or found a new location. It has also been our privilege to assist, without charge, several widows in settling the estates of their member-husbands.

Calls for library service continue to grow. So far

as possible all requests are filled the day received. The enlarged service from the Extension Division promises far greater benefits in the immediate future.

Your Secretary can only report progress on the effort to secure national and state recognition of the fact that expenses of physicians in attending post-graduate courses and scientific meetings are properly deductable upon income tax statements. It is hoped that results may be reported within the coming year.

The many activities of the Society might all be reported under this general head, but the foregoing are cited as examples wherein each member may compute a value to himself.

LAY EDUCATION

While efforts in this field are reported by the Committee on Health and Public Instruction, your Secretary calls attention to the fact that results of this work have already been seen that were not anticipated for several years to come. The legislature, reflecting public opinion, was never more sympathetic to the scientific problems and recommendations of the profession than at the session just closed. Clippings from the Society's weekly service to the newspapers of the state show that editors are appreciative of the value of health news, and they in turn are the medium for the informing of thousands of Wisconsin citizens each week. As an example of their cooperation attention is called to the fact that when the president sent each editor of a daily paper in this state a letter explaining the need of suppressing certain items relating to suicide cases, he received an immediate favorable reply and response.

The effect of educating the public at large as to the services available from their family physician and as to his problems but rarely can be seen in any direct fashion. It is a field of effort that must be of a continuous nature over a long period of time. Your Secretary ventures the belief, however, that persistence in this work will bring to the public wider and still wider realization of the progress of science and the benefits obtained and obtainable from it and at the same time bring to the physicians of Wisconsin the benefits that accrue to those who accomplish a high public service.

As an addenda to this report your Secretary makes three recommendations. This report may not be concluded, however, without emphasizing the fact that in the interest and cooperation of the individual members lies the strength of the State Medical Society of Wisconsin. The Society was formed that the members might do collectively that which could not be done alone. To the accomplishment of the collective aims, each member contributes ten dollars annually. During the past, however, the Society has called upon certain men to do something more,—to become an active officer discharging the responsibilities and duties in the fullest possible sense of the office to which elected, or to do some one task the fulfillment of which that member alone might best accomplish for the Society as a whole. As this Society grows, so will more and more members be called, if you please, to active service. It is to such work that your Society owes this present report of progress. It will be by such work that your Society will see future accomplishment what today appear to be our greatest problems.

Your Secretary finds it indeed a privilege to work with you. Respectfully submitted,

GEORGE CROWNHART.

RECOMMENDATIONS

Your Secretary respectfully suggests the following subject matter to the 1927 House of Delegates.

1. Committees on the study of hospital licensure needs and study of the nursing question are both committees of a special origin. Their work is far from complete despite the time that has been given. Rather than appoint new committees it is suggested that the House authorize the continuance of the present committees until such time as they may submit a final report.

2. The last House of Delegates authorized an appropriation of $650 for the purpose of defraying the expenses of a Secretaries' Conference. This sum provided for the cost of program material and partially covered the rail expenses of secretaries in attendance. It is suggested that this sum be made a continuing appropriation for such annual conferences.

3. For the past two years your Secretary has edited an annual supplement to the Journal containing a digest of all laws affecting the profession. It is now believed that this might be of far greater usefulness if indexed and published as a booklet of convenient desk size. This may be done and a copy furnished each member for $550. A continuing appropriation to this end is suggested.

MEMBERSHIP REPORT

August 15, 1927.

County Society	Last Year	This Year	Loss — Gain +	Delinquent	Deceased	Removed	New Members	Honorary
1st District—								
Dodge	30	25	—5	3	2	..	..	..
Jefferson	33	35	+1	..	..	..	2	..
Waukesha	51	50	—1	1	..	1	1	..
Totals	114	110	—4	4	2	1	3	..
2nd District—								
Kenosha	43	42	—1	2	..	1	2	..
Racine	46	45	—1	2	1	..	2	..
Walworth	26	25	—1	3	..	..	2	..
Totals	115	112	—3	7	1	1	6	..
3rd District—								
Dane	137	123	—14	14	3	1	4	3
Columbia	26	28	+2	2	..	..	4	..
Green	17	16	—1	..	1	1	1	..
Rock	78	77	—1	6	1	1	7	..
Sauk	25	19	—6	5	2	1	2	..
Totals	283	263	—20	27	7	4	18	3
4th District—								
Crawford	8	10	+2	..	..	..	2	..
Grant	32	32	...	..	..	..	..	..
Iowa	13	11	—2	..	..	2	..	..
Lafayette	16	15	—1	2	..	..	1	..
Richland	9	11	+2	..	..	..	2	..
Totals	78	79	+1	2	..	2	5	..

5th District—								
Calumet	13	13	...	..	..	..	..	..
Manitowoc	33	36	+3	..	..	..	3	1
Wash'ton-Ozaukee	29	24	—5	5	..	..	..	..
Sheboygan	49	54	+5	..	..	..	5	..
Totals	124	127	+3	5	..	..	8	1
6th District—								
Brown-Kewaunee	56	55	—1	5	..	..	4	1
Door	4	7	+3	..	..	..	3	..
Outagamie	39	41	+3	1	..	..	3	..
Fond du Lac	42	44	+2	..	..	1	3	..
Winnebago	60	53	—7	5	2	2	2	..
Totals	201	200	—1	11	2	3	15	1
7th District—								
Juneau	8	7	—1	2	..	..	1	..
La Crosse	53	50	—3	..	..	5	2	1
Monroe	20	16	—4	4	1	..	1	..
Trempealeau-J-B	26	23	—3	..	1	2	..	..
Vernon	11	11	...	1	..	..	1	..
Totals	118	107	—11	7	2	7	5	1
8th District—								
Marinette-Florence	22	22	...	1	..	1	2	..
Oconto	12	11	—1	1	..	..	..	..
Shawano	10	10	...	1	..	..	1	..
Totals	44	43	—1	3	..	1	3	..
9th District—								
Clark	16	16	...	1	..	..	1	..
Green Lake-W-A	19	18	—1	1	..	..	..	1
Lincoln	15	15	...	..	..	1	1	..
Marathon	37	38	+1	1	..	..	2	..
Portage	21	21	...	..	..	..	..	..
Waupaca	23	22	—1	..	1	2	2	..
Wood	24	22	—2	..	..	2	..	..
Totals	155	152	—3	3	1	5	6	1
10th District—								
Barron-P-W-S-B	37	40	+3	..	..	1	4	..
Chippewa	21	24	+3	..	..	..	3	..
Eau Claire & A. C.	60	56	—4	2	1	2	1	..
Pierce-St. Croix	20	24	+4	2	..	..	6	2
Rusk	8	8	...	..	..	..	..	..
Totals	146	152	+6	4	1	3	14	2
11th District—								
Ashland-B-I	28	18	—10	5	..	5	..	..
Douglas	37	38	+1	2	1	..	4	..
Langlade	11	12	+1	..	..	..	1	..
Oneida-F-V	14	17	+3	..	..	..	3	..
Price-Taylor	17	15	—2	2	..	1	1	..
Totals	107	100	—7	9	1	6	9	..
12th District—								
Milwaukee	575	559	—16	30	8	4	26	..
Grand Total	2060	2004*	—2	112	25	37	118	9

*In addition to the total membership thirteen members, now deceased, paid their 1927 dues.

COMMITTEE ON HOSPITAL LICENSURE

The Committee on "Licensure of Hospitals" finds it impossible to give a final report at this time. Communications have been received from many states with reference to their methods of handling the problem, and further investigation and consideration will be necessary in order to report on this important subject.

The need of some regulating policy is evident, and inasmuch as this is somewhat of a pioneer work, a most careful study is being made.

Respectfully submitted,
R. W. Blumenthal, Chairman.

COMMITTEE ON NURSING PROBLEMS

Your Committee on Study of Nursing Problems in Wisconsin begs leave to submit the following report:

At the present time nursing in this state is carried on by the following classes of nurses:

(1) The registered nurse who, after receiving a high school diploma, is given an intensive training of three years in a hospital having a specified standing. This training consists of practical clinical work, lectures and demonstrations. These nurses, after graduation, receive at present seven dollars per day for twenty-four hours service. When employed on special duty in hospitals these nurses serve but twelve hours, receiving six dollars per day, with the cost of board added. Special fees are provided for contagious cases, etc.

(2) Nurses who have received partial training in hospitals but because of incomplete training, are ineligible for registration. These nurses in many instances receive similar pay to the fully trained and registered nurse.

(3) Graduates of the Bureau of Home Nursing in Milwaukee. These nurses have been given lectures through one year, have had three months training in a hospital and have secured clinical training under the direction of a supervising nurse by actual nursing in homes. Such nurses receive $25.00 per week. This course of training has been made the subject of an exhaustive survey by the Milwaukee Community Fund Committee and recommendations have been made seeking to greatly enlarge this class of training.

(4) The untrained or so-called practical nurse. Many of these women, by reason of years of experience under physicians who have taken pains in giving instruction, have acquired a reasonable skill in nursing. Their chief value, however, consists in an ability to conduct the housekeeping and general care of the family during the period of employment. Too often patients are at the mercy of incompetent and occasionally vicious women who have been sent by employment agencies or secured through want ads, or otherwise, and have no references as to nursing ability, general intelligence, or even of honesty.

(5) Hourly nursing by Visiting Nurse Associations. These associations undertake visiting nursing in the home under the auspices of charitable organizations, although industrial companies use them for employees and their families, and their services are also available to private individuals for a small fee. This service, given by registered trained nurses, has proven very satisfactory.

(Continued on Page 498)

THE JOURNAL BOOK SHELF

Dental Materia Medica and Therapeutics. With Special Reference to the Rational Application of Remedial Measures to Dental Diseases. A textbook for students and practitioners. By Hermann Prinz, D. D. S., M. D., Prof. of Materia Medica and Therapeutics, The Thomas W. Evans Museum and Dental Institute School of Dentistry, University of Pennsylvania. Sixth edition, enlarged and revised according to the United States pharmacopeia, tenth decennial revision. Price, $6.00. C. V. Mosby Company, St. Louis, 1926.

Exodontia. A textbook of Exodontia, Oral Surgery and Anesthesia. By Leo Winter, D. D. S., Prof. of Oral Surgery, New York University College of Dentistry. With 329 illustrations. Price, $7.50. C. V. Mosby Company, St. Louis, 1927.

A Text Book of Medicine. By 130 American authors. Edited by Russell L. Cecil, M. D., assistant professor of Clinical Medicine, Cornell University, Medical School, New York. Octavo of 1,500 pages, illustrated. Cloth, $9.00 net. W. B. Saunders Company, Philadelphia and London.

Medical Clinics of North America. Vol. X, No. 5, Boston number, March, 1927. Octavo of 311 pages with 34 illustrations. Per clinic year, July, 1926, to May, 1927. Paper, $12.00; cloth, $16.00. W. B. Saunders Company, Philadelphia and London.

Diseases of the Digestive Organs. With special reference to their diagnosis and treatment. By Charles D. Aaron, M. D., Prof. of Gastro-Enterology and Dietetics in the Detroit College of Medicine and Surgery. Fourth edition, thoroughly revised. Illustrated with 174 engravings, 70 roentgenograms and 13 colored plates. Price, $11.00. Lea & Febiger, Philadelphia, 1927.

New and Nonofficial Remedies, 1927, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1927. Cloth. Price, postpaid, $1.50. Pp. 473 XLVII. Chicago. American Medical Association.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1926. With comments that have appeared in The Journal. Cloth. Price, $1.00. Pp. 73. Chicago: American Medical Association, 1927.

Overcoming Tuberculosis. An almanac of recovery. By Gerald B. Webb, M. D., former President, National Tuberculosis Association; President, Colorado School of Tuberculosis, Colorado Springs; and Charles T. Ryder, M. D., Colorado School of Tuberculosis, Colorado Springs. Third edition revised. Price, $2.00. Paul B. Hoeber, New York, 1927.

City Health Administration. By Carl E. McCombs, M. D., National Institute of Public Administration and New York Bureau of Municipal Research. The Macmillan Company, New York, 1927.

The Tired Child. By Max Scham, M. D., and Grete Scham, Ph. D. Price, $2.00. J. B. Lippincott Company, Philadelphia.

Methods and Problems of Medical Education. Sixth series. Division of Medical Education, The Rockefeller Foundation, 61 Broadway, New York City, 1927.

How to Make the Periodic Health Examination. A manual of procedure. By Eugene Lyman Fisk, M. D., Medical Director, Life Extension Institute, and J. Ramser Crawford, M. D., Assistant Medical Director, Life Extension Institute. The Macmillan Company, New York, 1927.

Practical Lectures on the Specialties of Medicine and Surgery. Delivered under the auspices of The Medical Society of the County of Kings, Brooklyn, New York. Second series, 1924-1926. With 110 illustrations. Price, $7.00. Paul B. Hoeber, New York, 1927.

Lectures on Internal Medicine. Delivered in the United States in 1926. By Knud Faber, M. D., Prof. of Internal Medicine, University of Copenhagen, Denmark. With 43 figures and charts. Price, $3.00. Paul B. Hoeber, New York, 1927.

BOOKS RECEIVED FOR REVIEW

Medical Clinics of North America. Vol. II, No. 1, Chicago number, July, 1927. Octavo of 294 pages with 26 illustrations. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

Manual of the Diseases of the Eye. For students and general practitioners. By Charles H. May, M. D., Director and visiting surgeon, Eye Service, Belleview Hospital, New York, 1916 to 1926; Instructor in Ophthalmology, College of Physicians and Surgeons, Columbia University, New York. Twelfth edition, revised, with 374 original illustrations including 23 plates, with 73 colored figures. Price, $4.00. William Wood & Company, New York, 1927.

Surgical Clinics of North America. Vol. VII, No. 3, Chicago number, June, 1927. Pages, 330, with 81 illustrations. Per clinic year February, 1927, to December, 1927. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

Potassium and Tartrates. A review of the literature on their physiological effects. By Ralph W. Webster, M. D., Prof. of Medical Jurisprudence in University of Chicago. The Commonwealth Press, Inc., 1112 South Wabash Ave., Chicago.

Nineteenth Report of the Henry Phipps Institute, University of Pennsylvania. For the study, treatment and prevention of tuberculosis. Henry Phipps Institute, Seventh and Lombard Sts., Philadelphia, 1927.

BOOK REVIEWS

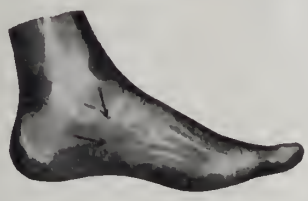
Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 153 E. Wells Street, Milwaukee, Wisconsin. These new books will be loaned for an inspection period only.

A Textbook of Clinical Neurology. By Israel S. Wechsler, M. D., Assistant Prof. of Clinical Neurology, Columbia University, New York; Attending Neurologist, The Montefiore Hospital, New York. Octavo volume of 725 pages with 127 illustrations. Cloth, $7.00. W. B. Saunders Company, Philadelphia and London.

The contents of this book are divided into five parts, Method of Examination, The Spinal Cord, The Peripheral Nerves, The Brain and The Neurosis. Part One is particularly well done. The interpretation of signs and symptoms is greatly aided by a brief description of the pathology underlying the various signs and symptoms. This part also embodies a chapter on psychometric tests, following the Stanford Revision of the Binet Simon Tests.

The diseases of the spinal cord, brain and the peripheral nerves are gone into thoroughly as regards signs and symptoms and diagnosis. Many excellent plates showing

DO NOT OVERLOOK THE FEET IN YOUR EXAMINATION



The symptoms of corns, callouses, bunions, burning, aches, pains, hammer toes, flat feet, and Morton's toe point to the falling of one or more of the arches of the feet. The x-ray picture above shows the cuboid bone dropped down along its inner border; and since this bone is the outer edge of the Posterior Transverse Arch, it proves that this, the main arch of the foot, has fallen.

Back of the falling of the three transverse arches and the two longitudinal arches we have a twisting of the os calsis with its lower border to the outside. This is proved by the bulging counter and run over heel—on the outside. Examine the shoes for these tell-tale marks.

Feet Cause Serious Trouble

Ptoses, pelvic pathology, backaches, insomnia, indigestion, etc., can all be caused by the feet being out of balance. The feet out of balance disturbs the balance of the entire body—spine, organs, etc., and serious conditions are the result.

Remove the Cause

Our ultra-simple appliance —the NATURE-TREAD —with the wedge at the heel to restore the os calsis into its proper place and the metatarsal elevation to remove the strain from the fallen transverse arches will establish the perfect balance and Nature does the rest. Write for our booklet, "Foot Ailments" and How Nature-Treads remove the cause.

Nature-Tread Co. of Illinois

655 S. Wells Street

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Or send your patients to our dealers—

Novelty Boot Shop, Appleton
Bowland Shoe Co., Baraboo
Fitzsimmons & Sons Co., Fond du Lac
Ascher Bercu, New Bargain Store, Fox Lake
Olson & Son, Frederic
Homer Maes, Green Bay
Barden Store Co., Shoe Dept., Kenosha
Cohn's Shoe Store, Kenosha
Rice & Thompson, 117 N. Fourth St., La Crosse
Schumacher Shoe Co., Madison
Walk-Over Boot Shop, Madison
Sol Friedstein & Sons Co., Marinette
Mr. H. J. Tuchscherer, Menasha
Kundert's Shoe Shop, Monroe
Nelson Shoe Store, Racine
Kahn Dry Goods Store, Racine
S. B. Gary, Rhinelander
Luck's Shoe Store, Rhinelander
Eugene Meyer, Watertown
Leo Ruesch & Son, Watertown
Porath & Schlaefer, 514 Third St., Wausau

AN INVESTMENT POLICY

Prosperous professional men who have accumulated a considerable surplus are much given to speculation, and not always wise in their ventures. One of them who adopted a definite policy ten years ago has told us his experience with it, which may be interesting. With a hundred thousand dollars' worth of stocks in 1917 he converted one-third of them into bonds, one-third into high-grade preferred stocks, and one-third into speculative stocks of companies which had good earning and dividend-paying records with one or two exceptions.

The income of both bonds and stocks, and the profits on occasional sales, were regularly applied to new purchases in the same proportion of bonds, preferred and speculative stocks. He selected in the beginning for speculative purposes U. S. Steel, American Steel Foundries, Allis Chalmers and oils, principally Standards, buying the common stocks of each. Every one of them yielded him profits. Allis-Chalmers, showing the least profit, and paying no dividends, was dropped not long after the close of the war. Had he held it, and invested $34,000 of it in 1917, his profits on a sale in May of this year would have been $77,000. But he was wise in diversifying his speculative purchases. Steel Foundries brought him larger profits than any other stock. He bought and sold it repeatedly, always at a profit. U. S. Steel he held through the entire period. His oils yielded him the least, and he is holding them at a loss.

But at present prices his bonds, preferred and common stocks show him an average profit of $10,000 a year during the ten-year period, including dividends and after all taxes. Not a bad example of prudent investment considering the postbellum reverses in stocks.

Reprint from The Chicago Journal of Commerce
August 4th, 1927

The accounts of literally thousands of our clients would tell a similar story — that the most consistently profitable account is that of the investor who **builds** *according to a definite Investment Program planned to fit his financial size, his family and himself, but supervised by his investment counselor so that changing economic conditions are profitably and safely anticipated and met. ~ ~ ~* ***Why not discuss your Investment Policy with us now?***

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pathologic processes and objective symptoms are all through the book. As closely as possible symptoms and the course of the disease are correlated with the disturbed function of the structures involved making the book an excellent one for students and those engaged in general practice. As the title implies, very little of the subject matter is devoted to treatment, although recognized forms of treated is mentioned for many of the conditions described.

That part dealing with the neurosis is a summing up of the modern views of the subject. Of the two most common concepts as to etiology, physiologic and organic, the author is inclined to accept the organic. The mental mechanisms that produce neurosis should be treated, the author believes, by psychoanalysis. The close relationship between the psyche and the internal glands and perhaps the vegetative nervous system he believes and that this relationship underlies to a certain extent the symptom complex of the neuroses.—M. Q. H.

Collected Papers of the Mayo Clinic and the Mayo Foundation, 1926, Rochester, Minnesota. Octavo of 1329 pages, with 386 illustrations. Cloth, $13.00 net. W. B. Saunders Company, Philadelphia and London, 1927.

This, the 18th volume of the Collected Papers of the Mayo Clinic, is fully up to the standard of the more recent volumes. It is quite impossible for anyone to review completely such a volume as this with several hundred articles.

The subject matter is divided into the Alimentary Tract; Urogenital Organs; Ductless Glands; Blood and Circulatory Organs; Skin and Syphilis; Head, Trunk, and Extremities; Chest; Brain, Spinal Cord, and Nerves; Technic, and Miscellaneous. The frontispiece is a photograph of Dr. Russell D. Carman, and there is an obituary notice as a preface to the book. Many of the articles are only short abstracts with references to the journals in which the completed articles can be found.

The book is a record of the now multiple activities of this well-known clinic, and places in convenient book form the many articles which have appeared in various journals written by the members of the clinic staff.

The illustrations are well done, the book is well edited and at the end is a complete index of bibliography as well as subject matter.—L. M. W.

Medical Clinics of North America. Vol. X, No. 6, Heart number, May, 1927. Octavo of 211 pages with 101 illustrations and complete index to Vol. X. Per clinic year, July, 1926, to May, 1927. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

This volume of the Medical Clinics is taken up almost entirely with a series of articles concerning the heart, given in a Seminar on Diseases of the Heart under the auspices of the Philadelphia County Medical Society during the fall and winter of 1926-27.

This seems to the reviewer one of the best numbers of this now very popular clinic. The articles are all by men who are authorities in their various subjects, and while one might differ with some of the statements made, nevertheless they are opinions of men who are competent to speak upon the subjects.

There is also included an article on Sickel-cell Anemia and an article on Indican: Its Periodicity of Elimination which expresses some rather peculiar ideas which may have to be taken at present with a grain of salt.—L. M. W.

Lippincott's Pocket Formulary. By George E. Rehberger, M. D., author of Lippincott's Quick Reference Book. This little pocket therapeutics has been prepared to provide the practitioner with a conveniently sized ready reference manual. Price, $3.50. J. B. Lippincott Company, Philadelphia.

This little book, which can be slipped in the pocket, should be very valuable to the average practitioner. There is a great deal of information condensed into its pages. There are a great many prescriptions for every conceivable disease and the arrangement is such that one can readily find the treatment for any particular disease. A valuable section is Part III, listing the new and nonofficial remedies with their dosage.

This can be highly recommended to the profession.—L. M. W.

The Human Body in Pictures. By Jacob Sarnoff, M. D., Associate Surgeon, United Israel-Zion Hospital, Brooklyn. A visual text of Anatomy, Physiology and Embryology. Price, $2.00. Physician & Surgeons Book Co., Brooklyn, N. Y.

This little book is a direct outcome of the moving pictures as illustrating various things in life. It is designed to be used with the films and yet at the same time it can be used as a text book for high school students. The illustrations are profuse and are largely taken from cuts of motion picture films which are numbered to correspond to the films.

The reviewer has felt that the teaching of physiology and anatomy in high schools should be a part of the regular curriculum. Every child should know something of his body. At present the teaching of this subject is almost ridiculous. The text books are old and sometimes inaccurate. In the hands of competent instructors such a book as this should be of great assistance and should materially help to place physiology and anatomy in their proper important place in the school curriculum. The book might also be used as a quick review of the essential points of anatomy and physiology.—L. M. W.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared original articles. By leading members of the medical profession throughout the world. Vol. II, 37th series, 1927. J. B. Lippincott Company, Philadelphia and London.

This well established quarterly contains a number of interesting articles and also includes notes on the clinics given in Europe to the men who joined the Post Graduate Travel Clinics. It includes articles on Diagnosis and Treatment, Medicine, Surgery, Public Health, Medical History, Travel Clinics, Post-Graduate Study, the address of President Coolidge before the Washington Meeting of the American Medical Association and gleanings from papers read before the Washington Meeting of the American Medical Association.

This volume is fully up to the standard which has been set by the International Clinics. The illustrations are well done and the book has its usual attractive appearance.—L. M. W.

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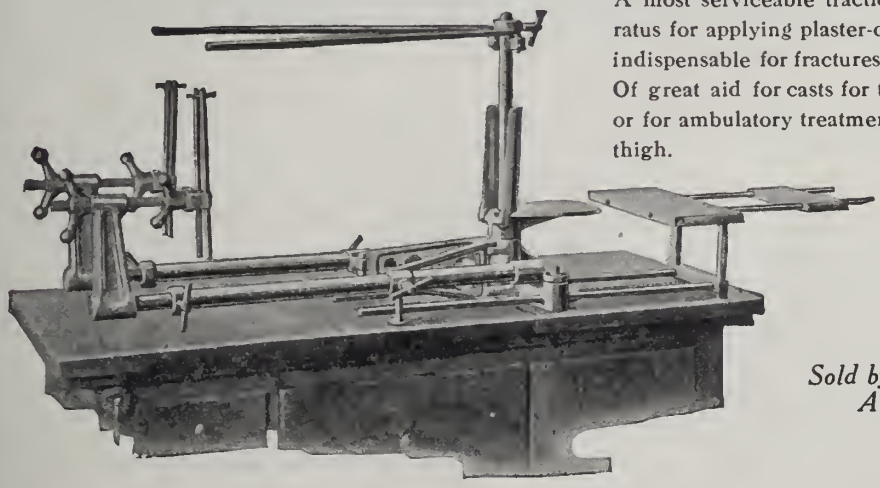

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Diseases of the Skin. A practical treatise for the use of students and practitioners. By Oliver S. Ormsby, M. D., Clinical Professor and Chairman of the Department of Dermatology, Rush Medical College of the University of Chicago. Third edition, thoroughly revised. Illustrated with 521 engravings and 3 colored plates. Price, $11.00, Lea & Febiger, Philadelphia, 1927.

In this third edition the author has maintained the enviable position attained by previous editions. A noteworthy feature of the book is that though much new material has been added and the entire text revised, it is no bulkier than previous editions. The practitioner and student will find the text easy to read, concise, practical and well illustrated. The dermatologist will consider it one of the few really excellent treatises on skin diseases. The bibliography references have been brought up to date and arranged and defined so as to be especially valuable for amplification of the text. The illustrations are good and excellently reproduced, the paper, printing and binding are of the best. The author's national and international standing as one of the foremost dermatologists of the present day is reflected in this work.—H. R. F.

DIAGNOSTIC PROBLEMS

(Continued from Page 461)

worker in a foundry entered the Milwaukee County Dispensary, April 26, 1926, complaining of pain in the upper abdomen. He said that on the night of April 12th he went to bed feeling perfectly well. About 12:30 A. M. he was awakened by a sharp pain in the upper abdomen half way between the naval and the end of the sternum. There was neither nausea nor vomiting. The pain has been constant since, at times worse than at other times. His sleep has been disturbed, his appetite has been poor. He had not had jaundice or fever. For a day or two his bowels were irregular but they have been moving normally since.

The family and past history have no bearing on the illness.

The patient walked into the dispensary. He did not appear very ill although he said he was in pain. He was well developed and nourished, with good color. The sclerae seemed very slightly tinged with yellow although the skin was free from color. The pupils reacted normally. The tongue was slightly coated, the teeth were in good condition. The lungs were normal. The pulse rate was 108. The heart sounds were clear and the heart was normal in size. As one looked at the abdomen a slight bulging was visible in the epigastrium. This was very slight, but definite. The respiratory movements were normal. On palpation a rounded smooth mass was made out, which was for the most part in the mid epigastrium, but extended slightly to the left. This was not particularly tender, it apparently did not move with respiration or with change of position from side to side and the percussion note over it was tympanitic. The edge of the liver was palpable, hard and sharp. The spleen was not felt. There was no tenderness elsewhere except over the gall bladder, and no masses were felt elsewhere.

A tentative diagnosis was made and he was transferred to the hospital. Urinalysis the day after admission showed dark red brown urine, 1024 specific gravity, acid, albumin 1, bile 3, no sugar. Microscopically there were occasional red and white blood cells and hyaline casts.

A blood count made on the day following admission showed 18,900 leucocytes with 70% of polys, and a very slight reduction in the red cells. On April 30th the leucocytes were 13,800, May 3rd they were 8,900. The Wassermann reaction of the blood was negative. The stools were light in color, did not contain occult blood. Some undigested starch was present.

Fluoroscopic examination of the stomach showed barium mixture entering the stomach normally. The stomach lay in high position, was steer-horn in shape, the lower border being midway between the umbilicus and the xiphoid cartilage. The pylorus was to right of the midline under the costal border. Barium passed out of the stomach in a fine stream, no cap was seen. There was a smooth filling defect, just proximal to the pars pylorica on both curvatures, greater on the greater curvature, which interfered with emptying of the stomach. There was no six hour residue, but considerable barium in the entire duodenum which was displaced towards the right.

While in hospital the mass seemed to grow larger. The patient had much pain. Once there was profuse vomiting. The pulse became faster and his general condition became weaker.

On May 5th operation was performed. After a somewhat stormy convalescence, he recovered completely.

This case will be discussed in next month's Journal.

COMMITTEE ON NURSING PROBLEMS

(Continued from Page 493)

It is self-evident that with the inability of at least seventy-five per cent of the population to employ the registered nurse whose training is highly specialized, it is imperative that provision be made by which legal recognition be given to a sub-standard educational requirement in which hospitals may give a course of one year's training leading to a certification and license.

Physician's Golden Opportunity

is being offered through the sale of this beautiful estate on one of our main state highways, about 40 miles northwest of Milwaukee and 18 miles south of Fond du Lac. With this estate goes a large and profitable practice over a radius of 10 miles or more, which means many times the population of the town itself. It being an excellent farming country, good pay on accounts is assured.

The grounds of this estate have a frontage of about 400 feet and about 150 feet deep, right on Wisconsin's beautiful "Rock" river, with fine trees, lawns, flowers and gardens. An ideal place for a sanatorium.

A View from the Home.

There is a modern 8 room house, with suite of offices attached, including laboratories, x-ray and operating rooms, fully equipped with the latest surgical instruments, such as are being used in our modern hospitals.

In addition there is a building to house 4 automobiles, a place for 3 horses, tools, etc. The second story of this building consists of a modern 7 room apartment. There is also a boat house, motor boat, private swimming pool, ice house, etc.

This estate has cost the deceased physician thousands of dollars, but will be sacrificed for less than half the cost. A reasonable down payment will be accepted and the balance on a mortgage.

For further particulars and appointment to inspect the premises, communicate with
D. A. STRAUSS, 202 Northwestern National Bank Bldg.,
Milwaukee, Wis.

An enactment of this kind might include an examination which would give a certificate of licensed nurse "L. N." or trained attendant "T. A."

Further, there should also be an annual registration of the so-called practical nurses, with a nominal fee, and a record kept of their experience, references by physicians who have actually had them in their employ, and such other data as may seem necessary, in order to give at least partial assurance as to the nurse's qualities, moral and professional.

It is hereby recommended that your committee be continued and that after more careful consideration a bill be introduced at the session of the legislature two years hence, defining the status of all persons who hold themselves forth as qualified to nurse the sick in the State of Wisconsin.

Respectfully submitted,
CHARLES H. STODDARD, Chairman,
KARL DOEGE,
R. C. BUERKI,
L. F. JERMAIN,
J. S. EVANS,
Committee on Study of Nursing Problems.

THERAPEUTIC NOTES

New and Nonofficial Remedies

In addition to the articles enumerated previously the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Lederle Antitoxin Laboratories

Erysipelas Streptococcus Antitoxin (Lederle) Unconcentrated.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

Crotalus Antitoxin—An antitoxic serum prepared by immunizing animals against the venom of snakes of the crotalus family. Evidence has accumulated to show that the venom of certain snakes may be neutralized by the employment of a serum obtained from animals that have been injected with venom from a snake of the same family. Crotalus antitoxin is used to neutralize the venom injected by the bite of members of the crotalus family. The serum is administered intramuscularly, subcutaneously and in certain cases it may be administered intravenously.

Antivenin (Nearctic Crotalidae).—North American Anti-Snake-Bite Serum.—An antitoxic serum prepared by injecting horses with venoms from serpents of the North American species of the family *Crotalidae* (Rattle Snake, 75 per cent; Copperhead, 12½ per cent; and Water Moccasin, 12½ per cent). It is claimed to have neutralizing effect against the venom of the species represented. The serum is marketed in syringes containing 10 cc. (a single dose). H. K. Mulford Co., Philadelphia. (Jour. A.M.A., July 2, 1927, p. 29.)

Erysipelas Streptococcus Antitoxin (Lederle) Unconcentrated.—An erysipelas streptococcus antitoxin (New and Nonofficial Remedies, 1927, p. 337) prepared by immunizing horses by subcutaneous injections of the toxic filtrate obtained from broth cultures of the erysipelas streptococcus, or by intravenous injection of cultures of the erysipelas streptococcus obtained from typical cases of erysipelas. It is administered in early cases of moderate severity in dosage of 12 cc. intramuscularly; in severely toxic and late cases, 36 cc. to 48 cc. intramuscularly, or 24 cc. to 36 cc. intravenously. This product is marketed in syringes containing 12 cc. Lederle Antitoxin Laboratories, New York. (Jour. A.M.A., July 30, 1927, p. 373.)

PROPAGANDA FOR REFORM

Disgusting Medical Advertising.—The medical profession is now being circularized with an illustration advertising presumably "Proveinase-Midy." The circular shows a disproportionate naked Hercules and a depressed naked female, whom the Hercules seems about to energize with "Proveinase." The name Midy has meant little that is inspiring to the American medical profession. Santal-Midy is sandal oil capsules that have been exploited largely by way of posters in public toilets. The advertising of "Proveinase" merits contempt and resentment. (Jour. A.M.A., July 2, 1927, p. 32.)

Plasmochin.—The Council on Pharmacy and Chemistry issues a preliminary report on "Plasmochin," a synthetic quioline derivative, developed in Germany and proposed for use in the treatment of malaria. For many years attempts have been made to find a substitute for quinine that would be cheaper, less bitter, less toxic and more specific than quinine. Plasmochin appears to be a step forward in this search, though it is not a full solution of the problem of eradicating malaria. It is said to act by destroying some of the forms of the malarial parasite and by inhibiting the development of others. Those who have studied the drug appear to agree that the new drug is most effective on the quartan forms of malarial parasite, that in tertian malaria a combination of the new drug with quinine is more effective, and that in birds the drug is sixty times more effective than quinine. The Council points out that results derived from the study of bird malaria have chiefly a suggestive value, and that further clinical study must be made before any optimistic estimate of its value in human beings can be formed. The Winthrop Chemical Co. has imported the drug for clinical trial and this is labelled to be "ethylaminoquinoline tannate." The firm states that the product when placed on the market in this country will be manufactured here. The Council has postponed further consideration of Plasmochin until clinical evidence concerning the efficacy, safety, and dosage of the product is available. (Jour. A.M.A., July 9, 1927, p. 113.)

Limitations of Goiter Prophylaxis.—Government authorities believe that there is no reason for special goiter prevention measures on the part of the state and local health departments. They do not see any necessity for universal prophylaxis such as may be attained by iodization of table salt or municipal water supplies. There is a growing opinion that the administration of iodine as a means of preventing goiter should be under the guidance of physicians and should be individualistic. In this way much good may be accomplished. (Jour. A.M.A., July 9, 1927, p. 114.)

The Wisconsin Medical Journal

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Address of the President; State Medical Society of Wisconsin, 1927*

By ARTHUR W. ROGERS, M. D.
Oconomowoc

In deciding upon a subject to present for your consideration at this time, I experienced considerable difficulty and no little embarrassment. It occurred to me that it might prove more valuable and instructive to dwell upon our shortcomings as a profession rather than upon our accomplishments, since we ever learn more from mistakes than from successes. The well-informed physician is ever alive to the progress which our profession is making as a whole, but is too busy to keep abreast of advances made along special lines of work. When one has had unusual opportunities to study and observe the work of some special department of medicine, it should be helpful to call attention to the points of contact between this specialty and the general practice of medicine, as well as the manner in which it serves the public. This is doubly true when that specialty has to do with the complete comprehension of the sick individual as a whole, and enters into the fundamentals of life and happiness and the welfare of our entire country.

With these statements in mind, it is my purpose to set before you some of the results of my thirty years' observation in a special field of work, as well as that of some of my superiors working along similar lines.

Of late years we physicians have been increasingly reminded, through the press, by laymen, and even by some of our colleagues, of things of which we are remotely conscious: viz., that the profession of medicine is undergoing a change; that there is a "wind blowing;" and even the word "revolution" has been used. We live in an age, and a country in particular, where changes take place so rapidly that a luxury of today becomes a necessity tomorrow. And it is possible that we as busy practitioners are not sufficiently cognizant of these changes. I am certain that many in our profession have sensed this blowing of the wind, and often ask themselves "Whither is it taking us?" With the rapid expansion of the science of medicine, the duties of the general practitioner have become so onerous that the tendency to enter special lines of work has naturally been growing. While the expert must of necessity possess a groundwork of general medicine, yet as the years slip by his interests and work incline to narrow his vision to his special line. All this inclines him to fail to "see the forest on account of the trees." In short, we fear that those of us who are working along special lines tend to forget the fact that we are dealing in the study of man with a complex organism, and not with one set of organs.

To be a successful practitioner of any specialty, one must have the entire human machine in mind, and particularly that part of the machine, the mind, which controls the whole. This has been termed the art of the practice of medicine, and it is this faculty which we are so often reminded that the present-day physician has lost. This point is well-emphasized by Dr. Wendell Phillips, president of the American Medical Association, when he remarks that "As for specialization, necessary as it is, it is not all of medicine. The knowledge of the specialist is as limited as it is profound in its own field; and, therefore, it is capable of serious errors. Coordination is essential. It tends necessarily to deal with the patient in piecemeal, and the patient happens to be an entity; a human being, not a case; a subtly interacting creature, who, to be treated with real science —that is, with real knowledge—must be studied and treated as a whole being. The science of medicine is the relief of human suffering. Research is essential to that relief. But it is, medically speaking, an aid and not an end. Specialization represents an important advance in the organization and use of knowledge, but it is an auxiliary, not the fundamental structure of the art of medicine."

*Presented at the Eighty-Sixth Anniversary Meeting, State Medical Society of Wisconsin, Eau Claire, Sept. 21, 1927.

After this rather lengthy introduction, let me proceed to point out those ways in which a working knowledge of neurology, abnormal psychological states, and psychiatry, can best serve the medical man as well as the public.

SERVICE OF NEUROLOGY AND PSYCHIATRY

Socrates once said, "There is no cure for the body apart from the soul; and the reason why so many diseases elude the physicians of Greece is that they know nothing of the soul." The ancients fully recognized the value of treating the mental side of man, but for many generations this was for the most part lost sight of, and with the advent of the laboratory with its refined methods, the soul of patients has almost been forgotten. It is not my intention to belittle any scientific method, but we must not permit ourselves to be so warped by them as to lose track of the fact that every sick individual is a human being with emotions as well as physical organs. It has been very apparent during recent years that the pendulum has begun to swing back, and I attribute this for the most part to the new psychology and the teaching of modern psychiatrists. Evidence the expression, "surgeons of the soul who will cure the mind of imaginary ills," as used on the floor of the recent meeting of the American Medical Association; likewise, the present flood of literature, lay and professional, dealing with mental states and their relationship to life, happiness, and the progress of the individual and the nation. Our pioneers have had a great struggle, but as usual the path of the pioneer soon becomes a highway.

That thing which is the most important thing in the world; that thing which has to do with our every action; that thing which interprets every ache and pain; and that thing which regulates our joys and sorrows; in short, that thing which controls all life's activities, is the least understood by man. I refer to the human mind. Those of you who read "The Mind in the Making" have a better conception of what this mind of ours has passed through to reach its present state of development. We as men of science are believers in the theory of evolution. From chaos we have come up to wonderful things; yet in this twentieth century we still find ourselves groping and endeavoring to classify and clarify mental activities. We have not been, and probably never shall be, able to define the normal mind, because this is an individual equation. Psychiatry is a study of pathological states of mind; but here, as in so-called physical conditions, one cannot go far without an understanding and a knowledge of the so-called normal mind.

The teaching of psychiatry, as well as that of psychology, thirty years ago was most elementary; and those in this audience who were students of medicine at that time will readily recall how little they extracted from their course in mental diseases. This was true even in our best medical schools. This was not so much the fault of the teachers, but was rather due to the fact that the subject was new and unknown. It has been in very recent years that psychiatry has come into its own, the psychoses recognized as disease entities and treated in a rational manner. The majority of mankind has ever been prone to display little interest in those things which they do not understand or which they consider complex. We as physicians have been too indifferent to delve into these matters; hence, psychology and psychiatry have been neglected by the rank and file of our profession.

ROLE OF THE MIND

It would indeed be poor taste on my part, in the presence of a body of scientific men, to call your attention to the part the mind plays in health and disease; but I cannot forego the privilege of stressing this point. Too often in our busy lives we are inclined to fail in the use of many potent agencies, though we may possess knowledge of them. None of us are proof against suggestion, and the more imaginative we are the greater our suggestibility. Unfortunately, unfavorable suggestion finds a resting place in our minds much more readily than that of a favorable character, just as grief is a stronger emotion than joy. How many forms of treatment, how many drugs, are used as purely suggestive agents? You can answer for yourself. At this very moment I venture to say that each of you is asking himself, "Am I influenced by suggestion?" Your answer of necessity must be in the affirmative, because it is a trait common to all mankind. Suggestion is the keynote to all mob activities; it is the backbone of the greatest false religious and pseudo-scientific sect which has swept this country in our generation. Suggestion is the most prolific source of suicide. Witness this in the suicide pact and in endemics of suicide of the same character and by the same means following wide publicity given by the press to some unusual and outstanding case.

If suggestion is so powerful an agent for good or evil in the strong and well, how much more so must it be in the mind whose vitality has been lowered by disease. The sick individual waits anxiously the sound of the doctor's footsteps; he listens attentively and analyzes every word the doctor says, as well as his every movement and expression. He is either helped or further cast down by every call the doctor makes. Sir Maurice Craig, writing for the LONDON LANCET on "Mental Symptoms in Physical Disease" remarks that "While the close relationship of mind and body has long been recognized, in practice this inter-relationship has been largely lost sight of, and the tendency has been to investigate them apart, to the detriment of our knowledge of each. It must be conceded that all physical disease has a concomitant mental change, just as all mind disorder is associated with variations in the bodily functions. In most persons prolonged pain is associated with definite mental changes, such as irritability and restlessness."

It is well and wonderful to develop our refined methods of diagnosis, but after the diagnosis what? You have heard much about periodic examinations in supposedly healthy individuals, but I have always believed that the most important part of this program was what came after the examination. The individual before you is on trial —in short, he is being examined. His mind is an open door through which we are to enter with our suggestions, the greatest relief or the greatest curse on earth. Now, where do we as physicians stand in this matter? Our surgeons have been tardy in recognizing this great power in their possession. It has been said that a highly emotional temperament is incompatible with careful surgery. This may or may not be true, but grant that it is the case; it is still possible to recognize the human side of the patient, and to take into consideration his emotions, and to conduct one's self accordingly. Dr. Thomas W. Salmon recently remarked that it is a "significant trend in modern medicine that it is leading the interest of physicians to the patient as a subject for study no less important than the disease itself." For some time Dr. Crile has been preparing and training many of his surgical cases and all of his toxic goiter cases for days prior to their operation; and in the latter class of cases he has operated on them frequently without the patient's being informed as to the day of operation. I feel confident that we would have fewer deaths from surgical shock if all surgeons would take the same attitude toward their patients, and I am equally confident that the patient would go to and through his operation much more calmly, comfortably and successfully, if more of the human element were taken into consideration. In the presence of illness, we must ever bear in mind this great therapeutic agent that we possess, and use it to the fullest extent.

PROGRESS OF PSYCHIATRY

In no other department of medicine has such satisfactory progress been made during the past fifteen years as in that of psychiatry. This has not been so much in the line of physical agencies as in a better understanding of psychology and the workings of the mind in healthy individuals, enabling us to better comprehend pathological states of mind. The man who does not sense the value of suggestion and properly apply it in psychopathic situations is of little value to his patient, because success lies mostly in the analysis of mental complexes, their illumination and consequent disappearance.

In the final analysis, all forms of sickness present morbid states of mind which require treatment equally with the physical condition. In psychotic states, the mental problem is the chief one; and unless we fit ourselves to cope with such conditions, unless we bring to bear more of the art of the practice of medicine, how can we expect to help the host of maladjusted individuals, behavioristic problems, and the other unfortunate and unhappy individuals who come to us for assistance? When we fail, they seek the charlatan, the unscrupulous, and the various -isms and -opathies, which at times, we must admit, do more for them than we do, simply because we do not take the time required by the patient to properly grasp the situation.

The psychiatrists have taught men of medicine, and are still struggling with the public, that insanity is a disease—a sickness of mind—often depending upon or aggravated by physical causes, and that under proper environment a large percentage of such cases recover. Under their influence we have witnessed the development of humane laws of commitment and care of the mentally ill. Jails, almshouses, restraint and abuse are rapidly being replaced by emergency hospitals and psychopathic clinics, by non-restraint, and by humane treatment. Medical schools are giving psy-

chiatry the place it deserves, and nurses' training schools no longer neglect the subject.

General hospitals seldom make adequate provision for mental patients, although they have a rather definite responsibility in such cases. More and better facilities are needed for the treatment of the emergency mental case, for the temporary care of cases pending commitment, and for the intensive diagnostic study and treatment of selected cases with a marked physical basis. Until such accommodations are made available in general hospitals, the barbarous custom of holding mental patients, innocent of crime, in jails and police stations will continue to reflect on this so-called enlightened era of civilization.

That the broadly trained physician should be familiar with the more common types of mental disease is indicated by the facts that more beds in public hospitals of this country today are occupied by patients suffering from the various neuroses and psychoses than by all other sick persons combined; that "every year sees more than 60,000 new patients admitted to institutions for the treatment of types of mental disease which are so severe in their manifestations that relatives, friends, or public officers cannot overlook them." General practitioners of medicine have the responsibility of dealing with nearly all these patients for weeks and months before they are brought to the attention of the psychiatrist. It is these early weeks and months that often constitute the really critical period of the whole illness. In them are largely determined the issues of recoverability or chronicity. With a definite increase in the psychoses, it is safe to remark that "if nothing is discovered to curb these diseases, while new discoveries continue to be made within the realm of bodily disease, then mental disease will supersede physical disease as the paramount social problem in the not distant future."

We whose work it is to deal with the life history of individuals readily come to contemplate life in general as something of an enigma. We become accustomed to the sight of pain and suffering which often leads to better things. Oftentimes group suffering and tragedy have the same result. Witness an epidemic of yellow fever of such proportions that men of science are stimulated to study and investigate, resulting in the practical elimination of that disease; or an holocaust such as the Iroquois Theater fire, snuffing out the lives of hundreds of women and children, causing life in the theaters of our land to be safe for the future. It was an individual tragedy which led to the conception and subsequent development of the one greatest movement directed to the study of the human mind in sickness and in health, and for the prevention of mental illness. It is to mental diseases what the periodic health movement is to so-called physical sickness—the mental hygiene campaign.

THE MENTAL HYGIENE CAMPAIGN

Not many years since a Harvard graduate, a physician of no mean mental capacity, passed through three years of a severe psychosis. During his convalescence he had a dream; and, fortunately, he was of the type who could make dreams come true. His book, "A Mind that Found Itself," is not only fascinating from a literary and scientific viewpoint, but it produced such a profound sensation that in a short time the author's power to envisage the future took form in the organization of the National Society of Mental Hygiene. Dr. Beers has from the beginning been its secretary, and he has ever been most indefatigable in his endeavors. The purpose of this society is to study the problems of insanity, the laws enacted in connection with it, the proper regulation of public and private institutions for the care of the insane, its causes, and, most of all, its prevention. Nearly every state in the Union at present has a branch society, and during the past year the movement has extended to the continent of Europe. During April, 1929, the first international congress of mental hygiene will be held at Washington, D. C. The parent society has for its officers some of the most outstanding men of the country, and it publishes a monthly magazine of great merit. It would be quite impossible at this time even to summarize the accomplishments of this organization, but it will prove enlightening to mention a few of them.

First of all, it is primarily due to this society that the medical profession and the public are being familiarized with the true nature of insanity, which naturally has led to more humane and scientific care, as well as lifting much of the curse from these maladies. Large sums of money are being expended in research work under capable men. Our penal institutions have been invaded, and we have gone far toward a clearer understanding of criminology, which has been placed on a more scientific basis. Surveys have been made of many of our larger universities, normal and pub-

lic schools, so that students can be properly classified mentally and directed into lines of study and activity compatible with their mental qualifications, thus making their success in life more probable. One large university has actually established a well-merited reputation for furnishing men and women to corporations as well as to individuals to fill positions of trust and responsibility. These students had been mentally analyzed and found to excel in certain lines. Yale University has recently established a chair of mental hygiene, and this fall Dr. Smiley Blanton, formerly of Wisconsin, assumes the same position at Vassar.

The advance of mental hygiene in colleges and universities has come with such rapidity in the last five years that it is no longer progressive to have an expert on mental hygiene on the staff, and to give as respectable a place in the curriculum to mental as to physical hygiene. It is reactionary *not* to do these things. If the dean of every university had a psychiatrist as an adviser there would be fewer student suicides and many students would go far who fail at the very beginning of their careers. Furthermore, such an adviser could instruct the faculty members so that they would possess an awareness of mental symptoms which would enable them to check a student at the very onset of some maladjustment period, and possibly head off a more disturbed experience. A person with a bad heart or a sluggish liver can get a fairly satisfactory education, but he has a poor chance indeed with ill-formed mental habits and a tendency to bad emotional disturbance.

MENTAL HEALTH OF COMMUNITIES

That the mental health of a community is as important as its physical welfare is obvious, but generally disregarded; obvious, because without mental health the most vigorous cannot maintain satisfactory social or economic adjustment; generally disregarded, because that residuum of medieval superstition clings tenaciously to our mentally sick and we are prone to disregard that which is either unpleasant or little understood.

Much of the psychiatric work, especially that of a preventive nature, and salvaging of the mentally ill which was done in our army during the late war grew out of this society's activities. Mental hygiene is an important part in many of our large industries. Witness the mental examination of large numbers of employees in order to classify them so that efficiency will be built up. Some railway systems have ordered regular examinations among those employed in their transportation departments, finding at times men with sclerosed blood vessels, incipient tabes, paresis, and even early psychoses, in positions where the lives of the public would be jeopardized.

Through the influence of the Mental Hygiene movement the Juvenile Courts of many of our large cities have called to their aid psychiatrists, and many mentally sick children have thus been saved from punishment and a life of crime. This same organization is responsible for the establishment of courts of domestic relations, likewise conferences of child health and parent education. Social workers are being trained to recognize mental irregularities, and thus enable them to intelligently prosecute their work. The Mental Hygiene movement is here to stay. It has originated forces for good far-reaching in character, which are affecting the individual, the state, and the nation. When we have inculcated this idea into the minds of parents, nurses, teachers, social workers, and the faculties of medical schools and universities, we shall have a splendidly trained corps of workers to handle the hygiene of body and mind of our youth.

APPLICATION TO GENERAL PRACTITIONER

Now let us turn for a brief consideration to the application of the principles of mental hygiene to the work of the general practitioner. The family doctor, as he comes and goes, in the homes of his patients, has an unusual opportunity of observing the mental makeup of its different members, of releasing and solving their various complexes, and of assisting them in adjusting to their environment, and even of participating in directing their careers.

There is nothing more intriguing in the entire realm of medicine than the knowledge of the power to direct and mould the human mind, especially that of the young. How often the family doctor is called upon to explain the bizarre conduct of some member of one of his families! It is not always a simple matter to distinguish between sickness and wilfulness, but usually there is a maladjustment behind the picture. He may be dealing with some grade of arrested development, or defectiveness, a post-encephalitic syndrome, an endocrine disturbance, or a mental state developing subsequent to some febrile movement; again, he may be facing an incipient neurosis or psy-

chosis; and upon his ability to properly recognize the situation depends too often the life and happiness of the individual before him. In the majority of such cases the early application of mental hygiene will solve the problem. "He who would be a psychiatrist must also be a physician, and in very truth he who would be a physician must ever and always be something of a psychiatrist."

By far the broader and more important aspect of mental hygiene is its relation to preventive medicine, and that there may not only be fewer "nervous breakdowns," but that so-called normal persons may lead still more efficient lives. It can advantageously be applied to every phase of human existence.

Dr. Lewellys Barker, president of the National Committee for Mental Hygiene, says, "The task which the National Committee for Mental Hygiene has set itself is an enormous one. It hopes by investigation, by education, and by organization, steadily to improve the brain-power of the nation. It is striving to hasten the time when our people will be so begot, and so reared, that their minds will develop normally and harmoniously; when society will have less need than now for sanitaria, asylums, and prisons; and when all but an irreducible minority of those born to membership in the nation may think, feel and act in a way that will make them desirable citizens of the Better State which is our goal.

"It is a great task, but surely not too great for the country that produced George Washington, and John Marshall, and Abraham Lincoln, or for the parents of a people to whom belong Benjamin Franklin and Ralph Waldo Emerson."

The great and lovable Dr. Oliver Wendell Holmes must have been dwelling upon such thoughts when he wrote:

"And last, not least, in each perplexing case,
Learn the sweet magic of a cheerful face,
Not always smiling, but at least serene;
When grief and anguish crowd the anxious scene
Each look, each movement, every word and tone
Should tell the patient you are all his own,
Not the mere artist, purchased to attend,
But the warm, ready, self-forgetting friend,
Whose genial presence in itself combines
The best cordials, tonics, anodynes."

Cerebro-Spinal Fluid; Comparative Studies of After Cisternal and Lumbar Puncture

By H. H. REESE, M. D.
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Within the last two years there has developed a tendency among neurologists to replace the lumbar puncture (L. P.) by the more modern cisternal puncture (C. P.). We know from experience that in approximately 20% of cases the patients complain more or less of severe headaches and even meningismus following the L. P., even if the best technique is used, and the patient remains flat in bed for more than 24 hours. This statement is especially true in individuals with normal spinal fluid, while in those with the pathological fluid, the complaints are fewer or there are none at all. The explanation for these after-effects is apparently the leakage of fluid through the puncture hole into the epidural space, which is possibly due to the increased pressure of the spinal fluid in the lumbar region. Other investigators confirm this observation which may last for days and which cannot be checked by any medication (sodium chloride, pituitrin, epinephrin, etc.), but only by prolonged rest in bed with the head down. We know that the pressure in the cisterna cerebra medullaris is negative in upright position and slightly positive when measured in the recumbent position. The technique of the cisternal puncture has been described in a paper by the author in the Wis. Med. Journal, 8:384 (Aug.) 1926. At first we employed the cisternal puncture only for diagnostic purposes in the determination of vague level symptoms in cases with spinal obstruction, by use of iodized oil injections. Now, also, we use the cisternal route for ventriculograms in which more than 60 c. c. of fluid are withdrawn and replaced by air, without unpleasant after effects and with better diagnostic results. If one is familiar with the cisternal puncture, one is greatly impressed with the ease of its performance. Naturally it is essential to know the anatomy of this region and the technique of such a puncture.

Many authors claim that there is a distinct current from the ventricular system downwards into the spinal canal, and that consequently the cerebro-spinal fluid differs in its cellular and chemical compositions at different levels. To study this question we have punctured a series of cases

in one session, in both the cisternal and the lumbar region. Our material was composed of neuro-syphilitics. The patient was placed on one side with the head slightly elevated and the neck slightly flexed. Then the head, neck and lumbar region was prepared for the puncture. We have always used local anaesthesia to keep the patient in an ideal position and to prevent nervous upsets. At first the C. P. was performed, and from 5-10 c. c. of fluid withdrawn, measuring the pressure; then the L. P. was done and the same amount taken off. The patient was put flat on his back and his complaints registered during 24 hours. The fluids were examined by the same technician, (Mr. P. Carroll), and were as follows:

	Relations in Normal Cerebro-Spinal Fluid		Relations in Neuro-Syphilitio Cerebro-Spinal Fluid	
	C. P.	L. P.	C. P.	L. P.
Pressure	0 to +	+ to ++	0 to +	+ to ++
Globulin	Neg.	Neg.	+	++
Cells	0 to 5	0 to 2	30—120	40—480
Gold Sol	Neg.	Neg.	+ to +	+ to ++
Sugar	40 mgm.	65 mgm.	80	105
Wassermann	Neg.	Neg.	+ to +++	+ to ++++

In meningitic conditions other than luetic, spinal fluid sugar determinations are lower, i. e., C. P. 30; L. P. 20-10.

In conclusion we state that in normal individuals the cerebro-spinal fluid has the same composition in the cisternal and in the lumbar region. In pathological fluids the lumbar is more strongly positive than the cisternal fluid. This is especially true in regard to the cells, goldsol and globulin contents; but we found also that the Wassermann reaction is, as a rule, stronger positive in the lumbar region. A very few exceptions of this rule do not change our opinion. The following two cases may demonstrate that the cisternal puncture alone will furnish us with incorrect results:

PAT. D.—Diagnosis: General Paresis, demented form—treated by malaria inoculation.

Blood Wass.—neg.

CIST.—cells 1, Nog. 0, R. J. 0, Wass. 0, gold s. 0122100000
LUMB.— " 0 " + " " + " 4+(1cc) " " 1233210000
3+(.5cc)

PAT. R.—Diagnosis: General Paresis, euphoric type.

Blood Wass.—neg.

CIST.—cells 0, Nog. 0, R. J. 0, Wass. 0, gold s. 1233210000
LUMB.— " 0 " + " " + " 4+(1cc) " " 2332110000
2+(.5cc)

The dangers of the C. P. are overestimated. When Quincke at first introduced the lumbar puncture, he had only a few followers, and today every physician is familiar with the technique of the L. P. As years go by, the C. P. will be used by more physicians as it is the puncture of choice in certain cases. Indications for C. P. are, in our opinion: Increased intracranial pressure, acute meningitis, tumors of the brain and cerebellum, severe neurosis, deformities of the spinal column and tumors and obstructions of the spinal canal. Contra-indications are: Chronic meningitis, tuberculosis of the upper cervical vertebrae, basal skull fractures.

In our opinion the C. P. cannot replace the L. P. Certain advantages of C. P. such as absence of headaches, and meningismus and less frequent blood contaminations do not equalize the less dangerous L. P. with its more simple technique.

Cholecystitis; The Diagnosis of*

By EDWARD F. MIELKE, M. D.
Appleton

Nothing is more difficult at times than to tell what is going on in the right upper quadrant of the abdomen. Disease of the gallbladder may simulate or be associated with other intra-abdominal pathology in many cases. With peptic ulcer alone about 30% of the gallbladders are diseased. One must have a clear conception of the early signs and symptoms of gallbladder disease to do successful abdominal surgery.

Pathology in the living is progressive. We, therefore, must follow the successive changes or natural history if we would have a comprehensive knowledge of the subject. We were taught in the early days much dead house pathology, and its importance certainly cannot be over-estimated. But in these late years we have learned the inestimable value of pathology in the living. At one time stones were considered the only evidence of gallbladder disease and at operation the gallbladder was carefully preserved. Today we have learned to center our attention, at least in the early stage which should be the all important one, on the gallbladder wall itself and not on the stones or free bile as the most important factors in calculus formation.

We have been taught that autopsy material will reveal gall stones in some 10% of adult bodies. This, however, is only a small part of the patho-

*Read before the Outagamie County Medical Society, June 30th, 1927.

logical story as shown by Mentzer of the Mayo Clinic. Mentzer finds that from autopsy material on over 500 bodies that in persons over 30 years of age gross and visibly pathology can be made out in a majority of these cases and with the microscope in 75% of them.

The early surgical pathology of cholecystitis may consist of but a single sign, though there are many to look for and to consider. The capacity of the gallbladder varies, of course, but is on an average about 40 c. c. The color is slate blue or olive green which fades rapidly as soon as it comes into contact with the air. Normally it is not red, dark, yellow, brown or mottled white. Its walls are thin, not thick; and no cholesterin deposits can be seen through the wall. Deposits of saffron colored fat on the fundus are abnormal.

Adhesions about the gallbladder and signs of pericholecystitis are not uncommon and usually indicate inflammation. They must, however, be distinguished from veils of peritoneum running between the gallbladder and duodenum, which is a more or less normal condition.

Palpable lymph nodes along the hepatic, cystic or common ducts are almost pathognomonic of cholecystitis.

The bile in the gallbladder is normally ten times as concentrated as that in the hepatic ducts. Little can be learned from it even by aspiration and microscopic examination unless the change is extreme, in which case the gallbladder may contain white bile, purulent or caseous material.

RESPONSIBLE FACTORS

The ducts will often show evidence of pathology. Marked twisting and curving or narrowing of the cystic duct can sometimes be made out and this often leads to stasis as has been shown by a number of surgeons. Three factors are mainly responsible for biliary tract disease: (1) Stasis of bile. (2) Infection either through the lymphatics or portal system. (3) Increased cholesterol content of the blood as commonly occurs in pregnancy and typhoid. Stasis whether occurring in the ducts or from spasm, obesity, pressure, visceroptosis, corsets, or constipation is an important factor. Whitaker says "The fundamental condition then, to gallstone formation is universally recognized to be stasis." Usually one *cannot* determine at operation stasis due to abnormality of the cystic duct but often the removed specimen will reveal the condition. Stasis leads to inspissated bile; this to cholesterin stones; and then should infection follow as it usually does, we would have the whole pathological picture. No doubt many a "normal" gallbladder removed for typical colic symptoms with complete relief was due to some abnormality of the cystic duct.

The normal blue, pencil sized common duct may be enlarged to thumb size and become thick and white in which case it should be explored.

The liver is involved in nearly all cases of cholecystitis to some extent consisting mainly of oedema, peri-cholecystitis and fibrosis according to Graham. It is usually enlarged especially the right lobe. It is often soft and oedemotous and prolapsed, yet it may be atrophic and scarred. The color is often red, yellow, or dirty. The edge is round, not sharp, and not rapidly "spreading like the normal ax-like edge." The edge is frequently crenated. The surface may be mottled, fine, or coarse. Lobulations, due to white fibrous tissue, are readily seen. Dimpling, white placques, and general fibrosis giving Glisson's capsule a thickened, uneven and granular surface are common. A triangular area of liver immediately adjacent to the gallbladder attachment constituting the area of lymphatic infiltration is frequently markedly cirrhotic and of a lighter color, while the rest of the liver seems quite normal.

The pancreas frequently shows abnormalities, and if present the chances are there will also be gallbladder pathology. Often there is hardness, stiffening, enlargement or "corn cob" feel of the pancreas.

A great deal has been written of late about cholesterol, cholesterosis and the strawberry gallbladder. These conditions are the most common pathological findings in gallbladder disease and are usually associated with some degree of inflammatory changes in the wall. The inflammatory changes in the wall may be the cause of these lipoid disturbances. The strawberry gallbladder without stones constitute about 25% of surgically removed gallbladders.

The term strawberry gallbladder is sometimes used as if it were a definite pathological entity or disease such as acute cholecystitis. This is not true. It is, however, a condition in which an ester of cholesterol is formed or deposited in the mucosa of the gallbladder. When this formation is so marked in degree that it becomes visible to the naked eye, the condition of strawberry gallbladder is present. This condition may or may

not be associated with stones. The mucosa is likened to a strawberry because of the red background dotted with these yellowish white lipoid deposits. When this cholestrin lipoid is piled up in localized polypoid areas, the condition then becomes a papillomatous gallbladder. How can one tell a strawberry gallbladder without opening it? This is often difficult. All the signs given before must be gone over, and in addition to these signs, one often finds a very thin walled sac through which the deposits can be seen.

It is an accepted fact that gallbladder disease is the most frequent organic cause of dyspepsia in adults and that this condition is responsible for about 20% of chronic dyspepsias. In a general way the other 80% are divided as follows: 30% to other intra-abdominal diseases, such as peptic ulcers, appendicitis, pelvic disease, etc., 20% to general systemic diseases, and 30% to functional disorders. Blackford reports almost three cases of cholecystitis to one of appendicitis in adults. Carman states that a clinical diagnosis of cholecystic disease was made in 5% of all cases observed in the Mayo Clinic in 1922.

It is a well known fact that a patient may have irritative gastro-intestinal symptoms for years with a cholecystitis before a typical attack of colic or jaundice. It is also hard to figure out at times why an apparently "normal" gallbladder will give rise to a typical colic syndrome while at the same time only 50% of the cases with actual proved stones in the gallbladder will give this same "colic syndrome". Some of these, no doubt, are "burned out cases" with a closed cystic duct and destroyed mucosa which might be likened to a healed and calcified tuberculous gland.

IRRITATIVE SYMPTOMS

The irritative symptoms of cholecystitis are, however, more or less characteristic and exhibit sufficiently definite and constant features to constitute a definite syndrome. The distress is constant rather than intermittant. It comes on immediately after meals and tends to improve as the upper digestive tract empties. The distress is entirely in the upper abdomen and characterized as a distension or full feeling with pressure upwards and a constant desire to belch. There is a burning distress in the stomach with acid eructations, usually definitely but temporarily relieved by soda. A careful selection of diet cutting out all fatty, greasy, or fried foods; highly acid foods, such as many of the raw fruits; fresh vegetables and well known indigestibles, such as cabbage, pickles, salads and so forth will markedly improve this dyspepsia. One must be careful, however, to rule out the 30% of functional dyspeptics with their chronic tiredness, chronic debility, nervous exhaustion, aching spines, neuralgias, parasthesias, headaches, and imaginative and inconsistent complaints.

Thorough exploration of the abdomen and long incisions have done much to diagnose these early cases of cholecystitis. The gallbladder must usually be seen to say whether or not it is diseased and palpation of the gallbladder from a low midline incision or appendix incision will only reveal gross and advanced pathology.

Frequently one sees a surgeon palpating the gallbladder from a low incision and hears this remark: "The gallbladder empties easily, is not under tension and contains no stones and is normal." These observations, I believe, do not entirely rule out gallbladder pathology.

Emptying of the gallbladder surely does indicate a patency of the cystic duct, but experience shows that a normal gallbladder often will burst from pressure before it will empty probably because of mechanical reasons. Failure of the gallbladder to empty may, therefore, be a normal condition while patency of the cystic duct does not rule out infection in the gallbladder wall.

The tension of the gallbladder also varies to a marked extent. Boyden of Harvard has shown that starvation produces a tense gallbladder and that after eating it becomes flaccid and remains so for some time. This is borne out by our present observation with cholecystography. Tension cannot, therefore, be always attributed to inflammation. It is often difficult to palpate stones in a tense gallbladder. Aspiration must be resorted to "to reduce the gallbladder to a flaccid state before the presence of stones or inflammation can be ruled out."

Even with the abdomen open one is often in doubt as to the wisdom of removing what appears to be a "normal" gallbladder. One must then rely on the clinical history and be influenced by statements such as that of Willy Meyer who says, "There is, I believe, no worse focus of infection than the diseased gallbladder without stones." And by the words of Judd who says "If the patient has had attacks of severe colicky pain he was almost sure to obtain relief by cholecystectomy, but the results of operating for

indefinite symptoms were very unsatisfactory." Henry Christian adds weight to this thought by saying "It needs to be recognized that symptoms antedate signs and that beginnings of disease may be present and productive of symptoms where no available method can detect abnormality in structure, and even tests of function record no change."

SUMMARY

(1) Cholecystitis is the most frequent organic cause of irritative gastro-intestinal symptoms in adults.

(2) The pathological signs of cholecystitis are most varied and many times fail to fit in with the clinical picture.

(3) Palpation of the gallbladder from a low incision will often fail to reveal early cholecystitis and even at times advanced pathology.

(4) A "normal" gallbladder must be removed, at times, on clinical evidence alone.

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Certain Pulmonary Diagnostic Difficulties

By LOUIS M. WARFIELD, M. D.
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Six years ago I saw a girl 19 years old who was brought up in a very religious family. She was a frail child, rather introspective. She gradually developed the delusion that she could not perform any action however trivial without biblical authority. If she could not find authority she was morose. The condition became so serious that she was placed in a sanitarium. There she became hysterical. She was regarded as a case of dementia precox and was locked up in the room for violent cases. She became so much worse that her parents became alarmed fearing that she would injure herself, so they took her out. At home again she quickly recovered from the attack of pseudo-mania. Then they brought her to me for examination. Upon carefully reviewing the history, taking into consideration her environmental influences, and after examining her, I concluded that she was suffering from tuberculotoxemia. Her parents contemplated moving to Colorado, the father was a minister, so I advised them to let her run wild. I lost track of them until a year ago I received a letter from her father asking me for a recommendation for his daughter who was applying for a position as school teacher. He also said that she was well and strong and had never had a return of her former trouble. The diagnosis in this case was made upon the history, the reaction to tuberculin intracutaneously, 1/10 mg. O. T., and the unusually large bronchial glands seen in the x-ray picture of the chest. There was practically nothing found on examination of the chest by percussion and auscultation.

I think we must admit the possibility of the production of peculiar mental symptoms in a sensitive, delicate young person under certain environmental conditions by the toxines of the tubercle bacillus. A competent psychiatrist very possibly would have recognized that her condition was not a true psychosis. Even competent physicians are not as well trained in psychiatric diagnosis as they should be, so that mistakes such as the above are apt to occur now and then.

The diagnosis of tuberculosis may be so easy that it can be made on looking at a person. It may on the contrary present great difficulty and only after repeated examinations and frequent observation is one able to arrive at a diagnosis. It may be made on simple physical examination, it

may need all the resources of our modern laboratory methods combined with physical examination and careful history. The diagnosis of tuberculosis should be approached as a differential diagnosis with all the possibilities that some other disease may be producing the symptoms and signs. Only in this way do I believe that we shall ever become more and more expert in finding the very early cases.

On the other hand the two diseases, tuberculosis and syphilis, are so protean in their manifestations that before any diagnosis is made these two diseases must be eliminated as causes. Probably more mistakes are made by not bearing this latter fact in mind than by missing a diagnosis when one is looking for tuberculosis or syphilis.

Tuberculosis has many modes of onset. In Osler's 9th edition for example there are ten listed: (1) Latent types, (2) With symptoms of dyspepsia and anemia, (3) Malarial symptoms, (4) Onset with pleurisy, (5) With laryngeal symptoms, (6) With hemoptysis, (7) With tuberculosis of the cervico-axillary glands, (8) With nervous symptoms, (9) With bronchial symptoms, (10) Following prolonged fevers, an activation of an old focus. Osler also says on page 191 "It is probable that many slight, ill-defined ailments are due to unrecognized tuberculosis." This has been my contention for a long time and is elaborated in articles published in 1925.

The onset of tuberculosis with cough, hemoptysis, pleurisy with effusion, etc., is so characteristic that one's attention is at once directed to the probability that the patient who has a history of one of these accidents has tuberculosis.

However, it is not so well recognized that neurasthenia, a psychosis, gastro-intestinal disease simulating gastric or duodenal ulcer, anemia in young people, anemorrhea in adolescent girls may be caused by tuberculosis. These may be called the less common modes of onset and yet in my own experience they have been far from uncommon. In a recent article I say "infection with tubercle bacilli gives rise to a series of vague and indefinite symptoms due to the absorption of toxic products from concealed tuberculous foci.—Months after the beginning of symptoms of toxemia there is some manifestation of clinical tuberculosis, so that there is a logical progression of the growing tubercles in the body from the time of indefinite toxic symptoms to actual demonstrable tuberculosis. This appears to me to be of great importance in the campaign against the spread of tuberculosis as far as any one individual is concerned."

The growth of the tubercle bacillus in the body explains the quotations above. Infection is now generally admitted to begin in infancy, shortly after birth if there is opportunity, such as a near relative in the household who has tuberculosis. The respiratory route is the common path of infection. The initial lesion is a tubercle with surrounding broncho-pneumonia usually followed by caseation and finally calcification or fibrosis. The regional glands at the hilum of the lung become tuberculous and go through the usual changes. One of several things may happen. If the infection is mild the primary focus heals, the hilum glands heal and the individual never has any further trouble. If the infection is more severe the initial focus heals but the glands only partially heal and in childhood there is bone, or joint, or gland, or other local tuberculous lesions, true metastatic foci. If the infection is severe the infant dies of tuberculosis. If the hilum glands are only partially healed the child may have anemia or be run down or have frequent colds; or if a girl, menstruation may begin normally then cease after a few periods. Either arrest takes place in this period or a quiescence takes place and in young adult life pulmonary tuberculosis then results. But what is taking place while the tubercles are increasing in number? Tuberculosis is usually a slowly progressive disease. Only rarely does it begin acutely, as when a ruptured tuberculous gland pours its contents into the blood or lymph stream. Therefore there must be a wide range between the growing tubercles which have not yet produced symptoms and the tubercles which are so numerous that they produce symptoms. The symptoms too must usually precede the signs, as they actually do. So that it is conceivable that one may present symptoms of absorption of toxic products from growing tubercles without showing demonstrable physical signs. Individual peculiarities and powers of recuperation determine the kind of response to infection.

VARIETY OF SYMPTOMS

When we view the tuberculous process in this light we can readily understand that there may be a variety of symptoms produced by the tuberculo-toxemia and that these symptoms produced may be general or referred to organs other than the lungs.

I would go so far as to affirm that a child between the ages of ten and eighteen who is anemic, loses weight, is tired all the time, can not keep up with classes and must be taken out of school, is suffering with tuberculosis provided that syphilis and chronic respiratory infection can be ruled out. If I go too far it is at least a safe rule to look upon every such child as tuberculous until proved not to be. So it is with so-called chlorosis and amenorrhea in girls. Tuberculosis may not be the cause but it is so frequently the cause that it should be definitely eliminated by differential diagnosis.

Neurasthenia used to be a much over-worked word. It was usually a confession of ignorance. As a term it expresses a motley group of symptoms of which the most characteristic is asthenia, not nerve but muscle asthenia. Any adult who complains of weariness at the task he formerly accomplished with ease should be viewed with suspicion. To say he or she is "run down", anemic, over-worked, etc., and let it go at that is to jeopardize the future of that individual. These symptoms are only too often the earliest symptoms of pulmonary tuberculosis. At this stage there may be little or nothing found on physical examination. This makes diagnosis difficult, even impossible. Treatment is usually successful if one bears in mind that he may be dealing with the earliest clinical manifestation of tuberculosis. The case is then not treated lightly but seriously and the physician watches the case carefully.

GASTRO-INTESTINAL SYMPTOMS

The onset with gastro-intestinal symptoms is, in my experience, rather common and frequently wrongly diagnosed and treated until suddenly a hemoptysis or an attack of high fever with cough jars the doctor to a realization of the true condition. How often I have seen scars of operation for gastric or duodenal ulcer in patients who should never have been touched with the knife. They needed a thorough examination from head to foot and not an x-ray examination of the gastro-intestinal tract. Our unfortunate era of specialization has both advantages and drawbacks. It has tended to breed a race of doctors who look upon the part as greater than the whole. Their intense interest in their specialty produces mental myopia. They seem to forget that symptoms in their particular organ are not always due to disease of the organ.

There are only two common diseases of the stomach, ulcer and cancer. All other abnormalities (I may be treading on controversial ground) of the stomach with symptoms on the part of the stomach result from conditions outside of the stomach. (I am aware that occasionally one sees syphilis of the stomach, rarely tuberculosis, more rarely echinococcus. I eliminate acute diseases, naturally I am speaking of chronic diseases only.)

An important study was made by Groover and Christie. Out of 1,300 cases sent over to them for gastro-intestinal study they found actual pathological lesions in 506, about 39 per cent. Unsuspected lesions were found in the chest in 170 cases. Of the cases referred for gastro-intestinal study, about twice as often pathological lesions were found in the gastro-intestinal tract as in the chest. There were 98 cases of the group in which the symptoms were on the part of the gastro-intestinal tract but the lesions were exclusively in the lungs. Of these, 84 were definitely due to tuberculosis and 14 were cases of pleural effusion, unresolved pneumonia, spontaneous pneumothorax, malignant disease, pleural adhesions and bronchiectasis.

I have seen patients with intense pain both after eating and with empty stomach. There are feelings of weight, oppression, gas, distaste for foods, and nausea. There may be vomiting but this is rare. Often there is constipation. The symptoms are somewhat like those of chronic ulcer, gallbladder disease, or chronic appendicitis, the last a much over-worked diagnosis. I have seen cases with scars of operation corresponding to these three diagnoses. Naturally the patients are worse after operation than before, and as their confidence has been badly shaken, it is more difficult to treat them successfully than it would be had the true diagnosis been made when the patient was first seen.

While in the majority, these reflex gastro-intestinal symptoms are early manifestations of toxemia and lung signs are few and difficult to find, often the lung lesions occupy the whole area above the third rib on one side and may be bilateral. It is a well known but nevertheless remarkable fact how extensive the lung lesions may be with little or no symptoms, and on the other hand how distressing gastro-intestinal symptoms especially may be with little objective lung lesion.

A typical case culled from a personal collection will be somewhat as follows: An adult, age 25

to 50, will complain of heartburn, bloating after eating, food feels heavy on his stomach, and belching. There is usually pain at some time of the day. It may be after, before, or between meals. The pain may be so annoying, situated usually right at the tip of the ensiform cartilage, that in his effort to get relief he reduces one food stuff after another until he actually is on starvation diet. The complaints may date back from a few months to several years during which time he had taken all sorts of drugs and had tried all sorts of diets. Occasionally he had periods of relief. These are usually attributed to the medicine or diet which he was taking just previously.

He complains of fatigue out of proportion to the energy used. He can not do his day's work. He can not think or concentrate as he formerly could. This is a very characteristic symptom. There is often constipation and unaccountable slight loss of weight.

He has been told frequently that he is anemic or rundown. A careful blood examination however does not show any very striking loss of either red cells or of hemoglobin. If the patient is a young woman she may complain of sudden cessation of menstruation or there may be dysmenorrhea or menorrhagia.

Patients do not often complain of fever. They never complain of nightsweats, pain in the chest or of cough. All the symptoms which distress them are from the gastro-intestinal tract.

Careful inquiry into the family history will in the great majority of cases reveal that one or both parents, an older brother or sister, a grandparent, died of or had tuberculosis and the patient was exposed to infection in infancy.

In the past history a most significant item is a period of ill-health between the ages of about ten to eighteen years. Often the child was kept out of school for a year or was not strong, did not play with other children, was moody and irritable. Usually a diagnosis of anemia was made and tonics and iron were given. Gradually the child recovered and often became heavier than at any other period since apparent recovery.

On physical examination there is no characteristic bodily conformation. I have seen the tall hyposthenic types and the perfectly normal types. There is nothing to be noted on inspection except occasionally a worried look on the face of the patient. Examination of the chest reveals often no definite findings. There may be evidences of a healed lesion at one or the other apex. Contraction of the apical resonance, slightly higher pitched percussion note, somewhat harsh breath sounds with prolongation of expiration are heard. Again there are evident signs of tuberculosis at one or both apices. The important point is that there may be practically no signs distinctive enough to warrant a diagnosis. In the abdomen there may be tenderness on pressure in the epigastrium and acute tenderness upon pressing the ensiform cartilage. The reflexes are usually exaggerated. The urine and blood examination show nothing abnormal. There is a variable amount of HCl in the stomach contents after the Ewald test meal, hypo-, or hyperacidity.

The examination of the gastro-intestinal tract with the x-ray reveals no lesion. Occasionally one finds the appendix still visible at the end of 48 hours. I do not believe that visibility has any significance. Stereoscopic x-ray films of the chest show no greater hilum shadows and no greater thickening of the bronchovascular tree than is often seen in perfectly healthy persons of corresponding age. Often, however, one sees evidences of a healed lesion at one apex. Often, too, the hilum shadows seem unusually large and have a fuzzy appearance.

An intradermal injection of 1/10 mg. of O. T. produces a reaction 4-6 cm. in diameter. This increased hypersensitivity is an indication that somewhere in the body there are active tubercles. Most adults will show some reaction, usually a red area for 1-2 cm. in diameter, at the end of 24 hours. This has no significance. Unless the reaction is large and definite it can not be looked upon as positive. The Wassermann reaction is negative and there is no evidence of a chronic tonsillar infection.

Dunham and Skavlem have called attention to the interesting fact that a diseased sinus can be present with no symptoms referable to the head. This must be borne in mind in making differential diagnosis.

The diagnosis is made then upon the history, a most important point, upon the absence of pathological findings in the gastro-intestinal x-ray examination, the absence of syphilis and chronic focal infection and upon the positive tuberculin reaction.

Nothing has been said about the exceedingly important examination of the sputum for tubercle

bacilli. The reason is that there is no sputum to examine.

There are cases who present the symptoms described within and who have definite physical signs in the lungs with tubercle bacilli in the sputum. These are not difficult cases to detect, provided one always bears in mind the frequent complaints of stomach symptoms in early tuberculosis of the lungs.

PROGNOSIS

Prognosis in these cases is usually good provided they are properly treated. I have reported upon the development of clinical tuberculosis from occult tuberculosis in the American Review of Tuberculosis, April, 1925. It is certain that people may have these vague symptoms for several years before there is unmistakable evidence of tuberculosis. Treatment: A régime of rest both physical and mental with three good meals a day will start theses cases on the up-grade. It is surprising what a few days in bed in an airy room will do for the distressing gastric symptoms. Without any other treatment and with no dietary restrictions except digestible food, the pain, belching, burning, oppression rapidly pass away and in a week the patient wants to get up and go back to his work. One of the differential points between the symptoms referred to the stomach and those due to gastric ulcer is just this effect of food while the patient is at rest. There are some mild cases of gastric or duodenal ulcer in whom pain leaves within two days after they have been put to bed. Usually, however, one can not feed these patients full meals without resulting discomfort.

In the mild cases, those whose symptoms have not been present for many weeks, who have lost but little weight, and have only a slight degree of fatigability, it suffices to send them on a vacation to the country for a month. I have seen men who could not eat a piece of milk toast without great stomach distress go into the woods with a camping party and inside of a week eat greasy flap-jacks made in a frying pan and never know that he had had stomach trouble.

There is one drug which I believe is a specific in this pretuberculous or occult tuberculous stage. This is cod-liver oil, and unadulterated. Empirically many have used it for years to "build up" people, little realizing that the reason for needing the "building up" was undoubtedly in most cases this tuberculo-toxemia malady. Within the last few years evidence has been brought forward that cod-liver oil not only actually inhibits the growth of tubercle bacillu *in vitro,* an effect which cotton-seed oil or other neutral oils do not produce, but it is a food and has the greatest content of fat-soluble vitamine (A) of any known substance. It is disagreeable to take but it can be rendered practically tasteless by adopting the following regime: Warm a spoon. Touch the tip of the tongue to a little salt in the palm of one hand. Put the warmed spoonful of oil far into the mouth and as soon as the oil is swallowed eat a salt cracker. From personal experience I can vouch for the fact that one tastes very little of the oil. Try it yourself.

Patients who have these very early symptoms should be carefully examined at intervals of six months, let us say. We are not doing our whole duty unless we carefully follow these people. The great majority get well and stay well provided they take good care of themselves. But there are some in whom the tuberculous process gradually advances to a recognizable stage with no return of the symptoms which previously annoyed the patient.

THE JOURNAL CLINIC

Diagnostic Problems

By LOUIS M. WARFIELD, M. D.
Milwaukee

Last month we presented the case of a young man, 31 years old, who woke up one night with violent pain in his upper abdomen. Two weeks later an indefinite rounded mass was felt in the epigastrium.

DISCUSSION

A bulging in the region of the abdomen just below the xiphoid cartilage usually means that there is fluid or tumor in the lesser peritoneal cavity. It seemed fairly certain that this mass

was in this region. The very sudden onset of pain suggested perforation of a gastric or duodenal ulcer. Such accidents have happened to people who previously never had had any gastric symptoms. However, the absence of collapse at the time, and the long period between the onset and the time he was seen seemed to make the diagnosis of fluid in the lesser peritoneum following rupture of a viscus rather improbable. The situation in the midline and the absence of pneumonia or pleurisy rendered the diagnosis of subphrenic abscess unlikely. The liver edge could be felt and this mass seemed deeply situated so it could not be an enlarged lobe. The smoothness of the mass, the absence of pain on pressure, the absence of repiratory movement and of postural movement, the tympanitic percussion note over the tumor, the absence of vomiting and fever seemed to reveal that it was not of inflammatory nature. The position corresponded to the pancreas, hence a diagnosis of pancreatic cyst was made. Hasty fluoroscopic examination showed that there was an indentation of the stomach, smooth in contour, which evidently was due to an extragastric cause. Diagnosis then seemed definite.

Further studies at the hospital showed leucocytosis, bile in the urine and gradual increase in size of the tumor. At operation through a median incision, a smooth mass was found behind the peritoneum. This contained a grumous, muddy fluid apparently having its origin from the pancreas near the head. Considerable necrotic material was also removed from the cyst. No calculi were found.

The wound drained for some weeks, leaving a small pancreatic fistula which by September was completely closed.

An article on Pancreatic Cysts by Friedenwald and Cullen will be found in Amer. Jour. Med. Sc. 172:313, Sept., 1926.

NEW CASE REPORT

On August 17, 1927, I was asked to see a high-school boy, 16 years old whose complaint was paralysis of the arms and legs.

There is nothing of importance in his family history which has any bearing upon the case and his past history is quite uneventful. The only disease which he ever had was pneumonia when he was a child. He has always been strong and healthy and a lover of the out-of-doors.

He was perfectly well on August 13th when he was painting his brother's auto and suddenly noticed that his legs were stiff. However, in the afternoon, although he could not walk as well as he had been walking, he went swimming. The next day his legs were much weaker and by afternoon he could not walk at all. He then noticed that his arms were weak and by the following day he was completely paralyzed, both arms and legs. He was taken to the hospital where a spinal puncture was done and the report made that there were only 5 cells. He had no fever, no headache, no gastro-intestinal symptoms and no backache.

When seen August 17th he was lying in bed on his left side with his head slightly retracted. He answered questions intelligently, told in consecutive form exactly how his paralyses had occurred, but was absolutely unable to move his legs except for slight twitching at one hip or to move his arms except for slight twitching at the shoulders. His voice was normal, he could still swallow but said that occasionally he seemed to have some slight difficulty. The tongue protruded in the middle line and was not markedly coated. The neck could be moved forward and was not really stiff. All the facial muscles including the jaw were under voluntary control. The pupils were equal, reacted normally. All movements of the eyes were present but there was nystagmus both lateral and vertical. The lungs, heart and abdomen showed nothing abnormal. Sensation was everywhere present. Both the deep and superficial reflexes were completely abolished below the neck. There was no fever, the pulse was 100, regular. He had complete control over his urine and feces.

August 18th a spinal puncture was again done which showed fluid under increased pressure, clear, no clot, 5 cells, globulin negative. The blood showed leukocytes 8,900 with a differential of polys 7%, small lymphocytes 20%, large lymphocytes 5% and transitionals 5%. The urinalysis was negative. The patient has had no fever at any time. The pulse has averaged about 74 with respirations 26. There has been no further paralysis. He is still quite conscious and still able to swallow.

On August 29th another spinal puncture showed exactly the same results. His general condition is probably slightly improved as he seems to be able to move his legs slightly when he gets over in certain positions. Tested with the electric current there was no response to the faradic but response to the galvanic. Sensations are still acute with no disturbances of any kind.

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SERVICE AVAILABLE

There is listed the following definite services that are available to our readers—the members of the State Medical Society of Wisconsin. If you have a need not covered here address the Secretary, Mr. J. G. Crownhart, 153 E. Wells Street, Milwaukee. "Let George do it."

FOR THE MEMBER

1. *Package Libraries* are now available on Cancer, Schick Test, Vaccination, Periodical Physical Examinations, Insulin, Fractures of Long Bone, Protein Treatment, Control of Communicable Diseases, Goiter, Digitalis, Pneumonia, Diseases of the Knee, Encephalitis, Asthma, Epilepsy, Meningitis and Scarlet Fever. Address Package Library Department, Extension Division, University of Wisconsin, Madison. Material on other subjects compiled upon request.

2. *Medical* Books will be loaned by the Medical Library, University of Wisconsin, Madison, Mr. Walter Smith, Librarian. Order through local library where possible.

3. *Physicians' Exchange Column* is open to all members without charge.

4. *New Scientific Publications* listed in the Book Review columns of this Journal are available for inspection by the members. They are in the Medical Library, University of Wisconsin, Madison. Place your order through your local library where possible or address Mr. Walter Smith, Librarian.

5. *State Laws* and departmental rulings can be secured through the Secretary's office.

6. *Legal Advice* upon questions pertaining to the practice of medicine will be given in so far as is possible. A complete statement of the question or facts must be forwarded.

7. *Inquiries.* Any inquiry with reference to pharmaceuticals, surgical instruments or any other manufactured product which you may need in home, office, sanitarium or hospital, will be promptly answered. Address all inquiries to Wisconsin Medical Journal, or write direct to Co-operative Medical Advertising Bureau, 535 North Dearborn Street, Chicago, Illinois. The Bureau is equipped with catalogues and price lists and can supply information by return mail.

FOR THE COUNTY SOCIETY

1. *Program Material.* Pursuant to authorization by the 1924 House of Delegates the Secretary is arranging to make program material available without cost. The following can now be secured:

A. Departmental Officers of the State Board of Health. Address Dr. C. A. Harper, State Health Officer, State Capitol, Madison, Wis.

B. Clinicians of the Wisconsin Anti-Tuberculosis Association when in vicinity. Address Clinic Dept., W. A. T. A., 558 Jefferson Street, Milwaukee.

C. Councilors and Officers of the State Society. Address the individual.

2. *Annual Statements.* Uniform annual statements can be had without cost. Address the Secretary, advising number desired.

EDITORIALS

"EAU CLAIRE IS THERE"

SUCH was the statement carried on letters announcing the Eighty-Sixth Annual Meeting of our Society. The statement was echoed time and again as members left the meeting for their homes. Working under the handicap of the limited facilities of a city of 25,000, the members of the Eau Claire and Associated Counties Medical Society and their wives accomplished wonders. Their hospitality knew no limits and both the scientific program and the arrangements showed the painstaking attention to details that made possible the unusually successful meeting.

As each annual meeting passes the observing member takes pride in the advancement of his State Society. Possibly at no previous session has such advancement been so evident as at the Eau Claire meeting. The work of the House of Delegates, the reports of the President and President-Elect, the Scientific Program and the work of the Committee on Arrangements all combined to mark a new high level in attainment of the group aim. "Eau Claire is there."

THE GLORIFIED GENERAL PRACTITIONER

IT IS a question if the general practitioner will always remain, or even if he is today, the bulwark of the medical profession in the fight against disease. In Chicago this year at the meeting of the committees on Education and Legislation, Dr. Graham of St. Louis deflated this idealizing of the family doctor to a considerable degree.

Dr. Pusey's articles on the general practitioner leave largely out of consideration good roads and easy transportation when he says the people in and contiguous to small towns are deprived of the medical attention they used to have. As a matter of fact, the rural population, in time and convenience, is nearer the medical man than it ever was before. I am sure the so-called "country doctor" or small town practitioner is earning a bigger income, and with greater ease, than ever before. The income of the doctor in a great majority of cases is larger than the same man would earn in a competitive field of business.

The story is told of a young doctor coming into a town where an old practitioner had had the field to himself for many years. The young man (quite unethically) hung out a shingle reading "Specialist in diseases of women and children." Somebody quizzed the old man about it, and he said, "Oh, H——, that's nothing; I'm a specialist in diseases of men, women and children."

There is a grain of truth underlying this tale. Nearly every doctor today has access to a hospital. He is a specialist apparently in all diseases. The nose and throat man today removes fewer tonsils than many general practitioners. The trained surgeon is likely to be doing fewer appendicitis (or should I say, appendiceal) operations than the general practitioner.

I have no intention of belittling the general practitioner; in fact I have been a champion of the general practitioner for many, many years; but the science and art of medicine are progressing so rapidly, the advances are so marked, especially in the field of physiology and biophysics and biochemistry, that the medical man of today, unless he is a constant and good student of the literature and is in the habit of frequent and sometimes prolonged post graduate clinical observation, is absolutely disqualified from practicing either medicine or surgery as it should be practiced. I am pleading for the medical practitioner, whatever field he may occupy, to give to his patient not the best that *he* can give, but the best that can be given by medical science. Access to good clinics where scientific work is being done is now so easy that the practitioner who goes along year after year without availing himself of such opportunities is, I believe, a menace to the profession, and the community in which he practices.

I believe that the art of medicine has become too mechanical. The senses that convey impressions to the brain and the gray matter that receives and interprets those impressions and transforms them into intelligent action, are too often

atrophic. I believe that the science of medicine is entirely too mechanistic, and the best trained recent graduate frequently forgets that there is something in his patient more than reflexes and reactions of a mechanical nature. Call it soul, or spirit, or what you will; there is something in all of us that cannot be governed or properly treated on the mechanistic theory. Psychology is not stressed in the medical school as it should be, especially as it applies to the practice of medicine.

The average doctor has not yet gotten beyond the conception of curative medicine. The rank and file know little and practice less the science of preventive medicine.

I should like to sum up with this query: Have the *science* and the *practice* of medicine ever been further apart than they are today?

E. E.

THE WORLD IS YOUNG

A RECENT article in THE ATLANTIC MONTHLY, "Business Has Wings," has many thought compelling suggestions, several of which might easily be applied in speculations on the practice of medicine of the future. The writer points to many amazing reorganizations of manufacturing and of merchandising establishments made necessary by new inventions, new fashions, and new demands of the buying public. With these business men, it has frequently been a case of effecting a rapid change of their ways or of going ignominiously to the wall. In the practice of medicine, we have not, as yet, been faced with any such precipitate menace to our time honored and customary habits of thought and action. But we may be, sooner than any of us realize.

A few years ago the manufacturers of hairpins, shoes, gloves and any number of other commodities had every reason to suppose that theirs were "basic industries" not likely to be affected by any whim of a fickle public. Prior to taking their losses, they felt much as we feel today. That whatever else comes to pass, sickness and accidents will always be with us and there will always be need of our reparative professional services. And there will, of course. But already we can hear the rumblings of the approach of a public demand for health service rather than service only to the sick and dying. Shall we resist this new demand as an unwelcome and unescapable obligation or shall we welcome and encourage it as an agreeable and promising opportunity?

To reasonably forward looking people, it must appear that there is more promise than threat in the prospect. Barring, possibly, some demagogic bits of social and class legislation which are more "progressive" in name than in fact, few of us would return to the "good old days," as a whole. We may cordially dislike arterial highways and automobile traffic police and signals; but most of us have no regrets of the passing of the old hog wallows which were called roads or the smelly, heavy laborious service of Old Dobbin. Looking back on the dying habits of the present time, we shall probably not care so much because they died.

The future will not be all beer and skittles for us doctors—nor for anybody else. But neither was the past. Furthermore, most of us do not care much for skittles except as a word. Many of us do not even know what it means. The doctors of the future are going to be a somewhat different breed of cats. But we have no reason to believe they will be any less happy or more poverty stricken than we are.

H. E. D.

MAC FADDEN PUBLICATIONS

MANY readers have sent this Journal copies of letters and other material they have received from the MacFadden Publications in which an effort is made to secure the endorsement of Wisconsin physicians for their publications and "Physical Culture Creed". In the language of the street, "It is to laugh".

MacFadden has frequently taken occasion to lambast the medical profession for its alleged shortcomings. Not in a dignified and honest critical spirit, but in the cheapest form of diatribe and for the presumptive purpose of adding to the self aggrandizement of Mac Fadden. Obviously, no physician "who knows his groceries" will lick the hand that has attempted to scourge him. It will be interesting and amusing, then, to note if any doctor of standing allows himself to fall into a trap so thinly disguised. An Orthodox Jew donating hoods and sheets to the K. K. K. would present no more amusing spectacle.

THE PRESIDENT'S PAGE

Arthur W. Rogers

THE STATE SOCIETY

EIGHTY-SIX years ago the State Medical Society of Wisconsin was organized and started on its way. What a privilege it is to learn from the few still living of its early days, and of the road they have traveled up to the present time!

It is gratifying to realize that our profession has outstripped all others in its progress, and that the passage of years has added greatly to its health, strength and prestige. Osler has said that the medical man seldom pauses to "take stock." Why not profit by his wisdom and "take stock" now?

Our medical forefathers organized because collectively they possessed more influence and power, and because it gave the individual members a prestige otherwise lacking. The long road from yesterday to today has been marked by struggle, combat, failures, and successes, but these have made us virile. It has been through organization that our story of accomplishment has been possible, and the better the organization the greater the assurance for future success. We are fairly well satisfied with the past, and now let us dream of the future. Vision is a mental attribute too frequently lacking in the majority of us, but to dream and to make dreams come true is the mark of statesmanship.

The physician of the past was more of an individualistic affair, while today he has not only his patients to serve, but he must consider the welfare of the public. He is a public servant, and he must become more so with the passing of years. Better so than have the state supersede him.

Dr. Ray Lyman Wilbur remarks: "The great problem before the medical profession as a permanent organization is one of its capacity to develop a sound fundamental program and to carry the essential plans of this program through a long series of years in spite of constantly changing external conditions."

Occasionally one hears a man say: "The State Society means nothing to me, and I get little from attending its meetings." He really does not mean that, but if he does, one is at a loss to know whether to pity more the man or his patients. Let the man stand forth who believes he can successfully practice medicine or possess the desired standing with the profession and the public without State Society affiliation! No one raises his hand. If then the Society helps him, why should he not contribute to its success? Failure to do so is evidence of selfishness or lack of pride.

Our Society will continue to increase in members, and to grow in influence. Growth means more work, a greater number of workers, and means with which to work. The day is at hand when a one-man secretary can barely discharge efficiently the duties required of him. We need funds to bring desirable speakers to our meetings, funds to assist the Board of Medical Examiners in ridding the state of nefarious quacks, funds to promulgate the subject of periodic health examinations and extend lay education, and funds for many other purposes. Our dream should be to devise ways and means to these ends.

The time is ripe for the establishment of a State Society Foundation, which, as it develops, will give its members an opportunity to turn funds into this foundation for the furtherance of the worthy projects of our organization.

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7th Dist., Edward Evans.....La Crosse
8th Dist., T. J. Redelings.....Marinette

TERM EXPIRES 1929
9th Dist., Joseph F. Smith.....Wausau
10th Dist., H. M. Stang.....Eau Claire

TERM EXPIRES 1930
11th Dist., J. M. Dodd.....Ashland
12th Dist., R. W. Blumenthal.....Milwaukee

Delegates to American Medical Association

H. M. BROWN, Milwaukee
J. M. DODD, Ashland
JOSEPH F. SMITH, Wausau

Alternates

W. E. BANNEN, LaCrosse
F. G. CONNELL, Oshkosh
R. E. MITCHELL, Eau Claire

Committee on Public Policy

O. B. BOCK, Sheboygan, Chairman
DEXTER H. WITTE, Milwaukee
D. L. DAWSON, Rice Lake

Committee on Medical Defense

A. J. PATEK, Milwaukee, Chairman
G. W. NOTT, Racine
E. C. CAREY, Reedsville

Committee on Health and Public Instruction

W. D. STOVALL, Madison, Chairman
R. E. MITCHELL, Eau Claire
H. C. WERNER, Madison

SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE
W. D. STOVALL, Madison, Chairman
L. H. PRINCE, Waukesha, Secretary

SECTION ON RADIOLOGY
GENTZ PERRY, Rhinelander, Chairman
HOWARD CURL, Sheboygan, Secretary

SURGICAL SECTION
C. J. COMBS, Oshkosh, Chairman
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MEDICAL SECTION
W. F. LORENZ, Mendota, Chairman

EYE, EAR, NOSE, THROAT SECTION
S. G. HIGGINS, Milwaukee, Chairman
W. E. GROVE, Milwaukee, Secretary

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The Wisconsin Medical Journal, Official Publication

LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES

County	President	Secretary
Ashland-Bayfield-Iron	C. J. Smiles, Ashland	M. L. Young, Ashland.
Barron-Polk-Washburn-Sawyer-Burnett	H. M. Coleman, Barron	D. L. Dawson, Rice Lake.
Brown-Kewaunee	E. S. Schmidt, Green Bay	M. H. Fuller, Green Bay.
Calumet	J. A. Schmidt, Brillion	H. C. Krohn, New Holstein.
Chippewa	C. B. Hatleberg, Chippewa Falls	W. C. Henske, Chippewa Falls.
Clark	S. G. Schwarz, Marshfield	F. P. Foley, Dorchester.
Columbia	A. F. Schmeling, Columbus	H. E. Gillette, Pardeeville.
Crawford	J. J. Kane, Prairie du Chien	C. A. Armstrong, Prairie du Chien.
Dane	W. D. Stovall, Madison	Hans H. Reese, Madison.
Dodge	L. M. Bachhuber, Mayville	A. A. Hoyer, Beaver Dam.
Door	John Hirschboeck, Forestville	T. C. Proctor, Sturgeon Bay.
Douglas	P. G. McGill, Superior	J. W. McGill, Superior.
Eau Claire and Associated Counties	G. W. Beebe, Eau Claire	H. M. Stang, Eau Claire
Fond du Lac	D. N. Walters, Fond du Lac	H. R. Sharpe, Fond du Lac.
Grant	E. C. Howell, Fennimore	M. B. Glasier, Bloomington.
Green	Edward Blumer, Monticello	J. F. Mauermann, Monroe.
Green Lake-Waushara-Adams	Orvil O'Neal, Ripon	J. M. Johnson, Ripon.
Iowa	A. D. Brown, Mineral Point	M. W. Trentzsch, Highland.
Jefferson	W. C. Becker, Watertown	A. C. Nickels, Watertown.
Juneau	C. A. Vogel, Elroy	A. T. Gregory, Mauston.
Kenosha	C. G. Richards, Kenosha	H. A. Binnie, Kenosha.
La Crosse	E. A. Smedal, La Crosse	N. P. Anderson, La Crosse.
Lafayette	W. W. Peck, Darlington	S. A. J. Ennis, Shullsburg.
Langlade	M. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	E. K. Morris, Merrill	W. H. Bayer, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	M. P. Andrews, Manitowoc.
Marathon	W. E. Zilisch, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	M. D. Bird, Marinette.
Milwaukee	C. H. Stoddard, Milwaukee	E. L. Tharinger, Milwaukee.
Monroe	H. B. Johnson, Tomah	H. H. Williams, Sparta.
Oconto	C. W. Stoelting, Oconto	C. J. Ouellette, Oconto.
Oneida-Forest-Vilas	C. D. Packard, Rhinelander	I. E. Schick, Rhinelander.
Outagamie	J. B. MacLaren, Appleton	C. D. Neidhold, Appleton.
Pierce-St. Croix	Rolla Cairns, River Falls	J. W. Prentice, Amery.
Portage	G. H. Lawrence, Stevens Point	F. R. Krembs, Stevens Point.
Price-Taylor	E. A. Riley, Park Falls	J. D. Leahy, Park Falls.
Racine	W. A. Prouty, Burlington	Susan Jones, Racine.
Richland	J. M. Ross, Richland Center	G. Benson, Richland Center.
Rock	W. H. McGuire, Janesville	H. E. Kasten, Beloit.
Rusk	L. M. Lundmark, Ladysmith	H. C. Johnson, Bruce.
Sauk	H. J. Irwin, Baraboo	Roger Cahoon, Baraboo.
Shawano	R. C. Cantwell, Shawano	C. E. Stubenvoll, Shawano.
Sheboygan	C. A. Squire, Sheboygan	G. J. Juckem, Sheboygan.
Trempealeau-Jackson-Buffalo	George Christiansen, Galesville	R. L. MacCornack, Whitehall.
Vernon	H. J. Suttle, Viroqua	Wm. H. Remer, Chaseburg.
Walworth	B. J. Bill, Genoa City	T. P. Keenan, Lake Geneva.
Washington-Ozaukee	C. A. Balkwill, Grafton	A. H. Heidner, West Bend.
Waukesha	C. C. Edmondson, Waukesha	J. F. Wilkinson, Oconomowoc.
Waupaca	T. E. Loope, Iola	A. M. Christofferson, Waupaca.
Winnebago	S. D. Greenwood, Neenah	R. H. Bitter, Oshkosh.
Wood	J. C. Hayward, Marshfield	V. A. Mason, Marshfield.

SOCIETY PROCEEDINGS

BARRON-P-W-S-B

The members of the Barron-Polk-Washburn-Sawyer-Burnett County Medical Society met at Frederic on Wednesday, September 7th. Dr. C. H. Jamieson presented an interesting paper on "Relation Between Modern Medicine and Modern Dentistry." Dr. W. A. Fansler, Instructor in Surgery, University of Minnesota, spoke on "Helpful Points in Rectal Examinations," and Dr. J. A. Watson, also of the University, on "Infection of the Ear and Para-Nasal Sinuses." "Rheumatic Fever" was the subject presented by Dr. S. R. Medley. Those in attendance were guests at a dinner given by the Frederic physicians at Diamond Lake Resort following the program. *D. L. D.*

DANE

The prevention and cure of tuberculosis was the main theme considered by fifty members of the Dane County Medical Society at a meeting at Morningside Sanatorium, Tuesday, September 6th. Dr. Louis R. Head, Madison, spoke on "Surgery of the Chest"; Dr. Oscar Lotz, Milwaukee, on "Detection of Pulmonary Tuberculosis by Physical Examination," and Dr. W. S. Middleton, Madison, on "Difficulties of Diagnosis of Pulmonary Tuberculosis."

Dinner was served at 6:30, after which a number of tubercular cases were presented by the sanatorium staff members. *H. H. R.*

OUTAGAMIE

The September meeting of the Outagamie County Medical Society was held on Tuesday, September 13th, at the Riverview Sanatorium. Dr. T. L. Harrington of the Wisconsin Anti-Tuberculosis Association, spoke following the dinner. He delivered a paper entitled "The Mistakes of Moses," which dealt with common mistakes in chest diagnosis. During the afternoon the physicians played baseball. *C. D. N.*

WASHINGTON-OZAUKEE

The members of the Washington-Ozaukee County Medical Society and their families enjoyed an outing at Thomas Resort, Little Cedar Lake, on Thursday, August 18th. Dr. Charles A. Balkwill, as president of the society, addressed the gathering and gave special emphasis to the subject of periodic health examinations. A paper on "Heart Failure and Its Treatment" was presented by Dr. L. M. Warfield, Milwaukee. The committee on fee schedule revision presented its report. *A. H. H.*

SEVENTH DISTRICT

Nearly one hundred physicians from La Crosse and vicinity attended the third annual meeting of the Seventh District Medical Society held at La Crosse on August 25th. Clinics were held from nine o'clock until noon at St. Francis Hospital, Grandview Hospital, Lutheran Hospital, and La Crosse Hospital. The following papers were presented at the afternoon session at St. Ann's Maternity Hospital: Dr. A. W. Adson, Mayo Clinic, "Spinal Puncture and Its Diagnostic Value"; Dr. R. M. Waters, Professor of Anesthesia, University of Wisconsin, "Advance in Anesthesia"; Dr. Henry L. Ulrich, Professor of Internal Medicine, University of Minnesota, "Chest Diagnosis."

The evening program was presented at the Chamber of Commerce following a 6:30 dinner, the speakers including Dr. Arthur W. Rogers, President of the State Society; Mr. C. D. Lehman, State School, Sparta, and Mr. J. G. Crownhart, state secretary.

Dr. W. E. Bannen, La Crosse, was elected president of the society for the ensuing year and succeeds Dr. Herman E. Wolf. Other officers are: Dr. C. Vogel, Elroy, vice president, and Dr. R. L. MacCornack, Whitehall, secretary. Whitehall will be the place of meeting for 1928. *D. S. S.*

NEWS ITEMS AND PERSONALS

Dr. Damon A. Brown has announced the opening of his office at 14 East Mifflin St., Madison. He will specialize in urology. Dr. Brown is a graduate of the Washington University School of Medicine, St. Louis, and was formerly affiliated with the Jackson Clinic.

—△—

The personnel of the Schiek Clinic at Rhinelander was completed during August and the organization is fully equipped in its quarters in the Merchants' State Bank Building. The physicians who have recently joined the clinic are: Dr. J. R. Newman, internal medicine. Dr. Newman is a graduate of the University of Wisconsin and received his degree at Rush Medical College, Chicago. He was resident physician at St. Luke's Hospital, Chicago, for eleven years and later became associated with the Medical School at the University of Wisconsin.

Dr. Gentz Perry, x-ray examination and treatment. Dr. Perry, a graduate of the University of Minnesota, will operate and direct the x-ray department.

Dr. L. O. Helmes, pediatrics. Dr. Helmes is a graduate of the Washington University School of Medicine, St. Louis, and was formerly affiliated with the Milwaukee Children's Hospital.

Dr. A. F. Harter, eye, ear, nose and throat. Dr. Harter graduated from the Wisconsin College of Physicians' and Surgeons', Milwaukee, in 1904.

Dr. T. M. Anderson, dentist, is a graduate of Northwestern University Dental College and comes to the clinic from Chicago.

Dr. I. E. Schiek, executive head of the clinic, is surgeon and consultant physician.

—△—

Dr. J. Travenick, Jr., of Columbia, S. C., has become associated with Dr. George M. Dill in the practice of medicine at Prescott. Dr. Travenick is a graduate of the Vanderbilt University School of Medicine, Nashville, Tenn., and served his interneship at the Louisville City Hospital, Louisville, Ky.

—△—

Dr. A. H. Kulig, Turtle Lake, has recently purchased the practice of Dr. F. D. Jackey of Thorp.

Word has been received that Dr. Vernon Stiles, city health officer of Sparta, is very ill and in a critical condition at St. Mary's Hospital of that city. This spring Dr. Stiles suffered a stroke from which he partially recovered. During the summer the doctor, with his family, has camped at Lake Wissota, and here the rest and quiet and fresh air seemed to benefit him and friends were hopeful that he was gaining. Another stroke came in August, however, and since that time he has been seriously ill.

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Arrested at the gates of the federal prison at Fort Leavenworth after having served two years of a four year sentence for conviction on a charge of stealing war compensation checks from the mails, Dr. Lewis Cohen, former Milwaukee physician, was taken to the state penitentiary to begin a ten-year sentence for assault and robbery as accessory.

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Does Chippewa County need a sanatorium? This is the question which is being asked in that locality in anticipation of the sanatorium issue before the county board. Dr. R. C. Rodecker, Holcombe, president of the State Board of Medical Examiners, is one of the Chippewa County physicians who answers this question strongly in the affirmative.

"During 1926 there were, according to the State Board of Health, thirty-seven deaths from tuberculosis in this county. Physicians estimate that there are nine active cases of tuberculosis for every death from the disease. If this is true for Chippewa County then we have approximately 330 active cases at the present time. Surely a provision for beds for fifty of these people would be a thing which Chippewa County owes to itself."

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Dr. L. J. Moriarity, Two Rivers, sailed for Europe on September 8th. He will study at the surgical and pediatric clinics of Berlin, Budapest and Vienna. Dr. Weichman, his assistant, will have charge of Dr. Moriarity's practice during his absence.

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Dr. Elmer L. Sevringhaus, of the University of Wisconsin Medical School, has been transferred from associate professor of physiological chemistry to associate professor of medicine, and associate physician to the Wisconsin General Hospital. He will continue acting as chemist to the hospital and also to carry out research work in similar lines as has been done for some years past.

Dr. E. J. Witzeman, formerly with the Mayo Clinic, has been appointed assistant professor of physiological chemistry to fill the vacancy caused by the transfer.

—△—

Dr. B. C. Brett, distinguished Green Bay citizen and one of the oldest members of the medical profession, celebrated another birthday Tuesday, August 23rd, when he became ninety-four years of age. Dr. Brett was given a reception at the Green Bay Y. M. C. A., where a host of his old friends were present to greet him and pay their respects to this physician, who "spent himself for the betterment of others."

Dr. W. E. Fairfield and Dr. A. O. Olmsted, Green Bay physicians, spoke in honor of the veteran physician.

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The first unit of the new Methodist Hospital, Madison, affiliated with the Jackson Clinic, was dedicated at the formal opening on Thursday, September 15th, to Sunday, September 18th. The official dedication took place on Thursday while the remaining three days was in the nature of open house for physicians, former patients and the general public.

The dedicatory program, held in the Assembly Chamber of the State Capitol, follows:

Invocation, Dr. Fred W. Harris, district superintendent; Greetings, by Hon. Fred R. Zimmermann, Governor of Wisconsin; Hon. Albert G. Schmedeman, Mayor of Madison; Dr. E. S. Gilmore, Secretary, the Board of Hospitals, Homes and Deaconess Work, and Dr. Reginald H. Jackson, Chief of Staff. Addresses were delivered by Dr. Glenn Frank, President, University of Wisconsin; Bishop William F. Anderson, Boston, and Dr. Franklin Martin, Director-General, American College of Surgeons. Bishop Charles Edward Locke gave the dedicatory address.

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Dr. H. H. Christofferson has announced that he will resume his professional practice at Colby.

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Dr. James A. Murphy, who served his interneship at the Madison General Hospital three years ago, has announced his return to that city and the opening of offices at 1357 University Avenue, Madison. During his absence, Dr. Murphy was a member of a Cleveland hospital staff, specializing for a year in obstetrics and pediatrics, and devoting another year to general practice. He is a graduate of Marquette University Medical School, 1924.

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Coming home through the clouds at the rate of a mile and a half a minute is not the usual route taken by members of the State Society, but that is the manner in which Dr. F. L. Hodges and Dr. W. D. Stovall, Madison, returned from the annual meeting at Eau Claire. Faced with the tedium of 190 miles of travel after the close of the meeting, Dr. Hodges had a pilot from the Madison Airways Company call for him and he was back in Madison just two hours and ten minutes after he left Eau Claire.

DEATHS

Dr. David W. Ashum, Eau Claire, died suddenly on September 3rd at the home of his daughter, whom he was visiting at Highland Park. Dr. Ashum was born in 1854 and graduated from the Eclectic Medical College of Cincinnati in 1881.

The deceased was a member of the Eau Claire and Associated Counties Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by a son and a daughter.

Dr. Francis P. Quinn, Milwaukee, died at St. Joseph's Hospital on August 30th from aplastic anemia. Dr. Quinn was born in Milwaukee in 1897 and received his degree from Marquette University Medical School in

1924. He was a member of the staff of St. Joseph's Hospital, Misericordia Hospital and the Marquette University Hospital and Dispensary, and was affiliated with the Milwaukee County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. Dr. Quinn is survived by his mother and two sisters.

Dr. Peter F. Gaunt, Milwaukee, died Monday, September 5th, at Marquette Hospital following an illness of two months. Dr. Gaunt was a member of the staff of the Deaconess Hospital and the Marquette Hospital and for several years taught classes in surgery at the Marquette University School of Medicine. He was a graduate of the St. Louis College of Physicians and Surgeons in 1902.

The doctor was a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. Surviving him are his wife and six children.

Dr. Richard S. Schroeckenstein, Marion, died on August 15th at a Wauwatosa sanitarium, where he had been admitted for treatment following a stroke. Dr. Schroeckenstein was born at Calumet Harbor, Fond du Lac County, December 12, 1860, and was graduated from the Keokuk Medical College, Keokuk, Iowa, in 1891. He has practiced his profession at Marion since his graduation.

Dr. Schroeckenstein was a member of the Waupaca County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He is survived by an aged mother, a sister and a brother.

MARRIAGES

Dr. Erich Wisiol, Stevens Point, to Miss Karleanne Scharman, of Marshfield, at Marshfield on August 29th.

CORRESPONDENCE

MINNESOTA LICENTIATES NOTICE

Minnesota State Medical Association,
11 West Summit Avenue,
St. Paul, Minn.

September 2, 1927

Dear Doctor:—

NEW BASIC SCIENCE BOARD

The new Basic Science Board, created at the last Legislative Session, is now in full operation, and has headquarters at the office of the secretary-treasurer, Dr. E. T. Bell, 110 Anatomy Building, University of Minnesota Campus, Minneapolis, Minnesota.

FAILURE TO REGISTER BY OCTOBER 1 CARRIES PENALTY

Application blanks and a letter of instructions have been sent to all physicians in the state, whose names appear in the American Medical Association Directory of 1927. It is important that application blank be filled out completely and correctly and returned to Dr. Bell's office with a check for $3.00 before October 1. Failure to register by October 1 submits you to the following penalty—you will either have to take the examination in the Basic Sciences, or you will have to show good cause why you did not file your application prior to October 1, 1927, and the Board will issue a certificate in its discretion upon the payment of a fee of $25.00.

INQUIRIES

The following questions have come to the Basic Science Board and to the Secretary of the State Association:—

Q. Where do I register?

A. At the office of Dr. E. T. Bell, Secretary-Treasurer, Basic Science Board, 110 Anatomy Building, University of Minnesota Campus, Minneapolis, Minnesota.

Q. What is the fee?

A. Three dollars ($3.00) must accompany the application blank. After October 1, 1927—$25.00.

Q. Is my license registered with the Clerk of Courts?

A. Yes, it must be registered with the Clerk of Courts, and he must also fill out the certification on the bottom of the application blank sent you by the Basic Science Board before it is returned.

Q. Do I have to register if my residence is in an adjoining state and I have a Minnesota license so that I can practice on both sides of the boundary?

A. Yes, you must register your Minnesota License with the Clerk of Courts in the Minnesota county in which you do most of your practicing, also with the Basic Science Board.

Q. What should I do, I failed to register my license with the Clerk of Courts and it has disappeared?

A. Write the secretary of the Minnesota State Board of Medical Examiners, Lowry Building, St. Paul, Minnesota, and ask for a certified copy. This will be sent to you, and must then be registered with your County Clerk of Courts.

Q. Suppose I do not receive an application blank from the Secretary of the Basic Science Board?

A. If you have not received an application blank from the Basic Science Board or if you have lost or mislaid the one you did receive, write the Secretary's office at once asking for same. Failure to receive the blank will not excuse you from paying the penalty.

There may be some physicians who will not receive the application blank from the Basic Science Board due to the fact that no one knows at this time who is entitled to practice in Minnesota. The principal reason for requiring registration is to obtain such information.

The Basic Science Board is taking the American Medical Directory as their basis of procedure. If you should have occasion to know that your name is not in the directory, by all means write the Secretary of the Basic Science Board for your application at once.

Q. Does the new Basic Science Law affect the license of physicians already licensed in Minnesota, but living in other states?

A. Yes, it is necessary that you file your license with the Clerk of Courts in the county you may expect to return to and make application for registration to the Basic Science Board the same as any licensed physician in Minnesota.

Q. What am I to do with the Basic Science certificate when I receive it?

A. Register it with the County Clerk of Courts within thirty days and then put in a conspicuous place in your office.

Q. Many are sending their application blanks in to the Secretary of the Basic Science Board incompletely filled out. Will they be penalized?

A. Failure to give the complete information required by law to the Secretary of the Basic Science Board will necessitate your making application for examination and actual examination in the Basic Sciences, provided, however, the Board may issue in its discretion upon payment to it a fee of $25.00 a certificate of registration. Applicant must, however, show good cause why said application was not made on or before the first day of October, 1927.

Remember — unless your application, completely and correctly filled out, accompanied by a check for $3.00, is in the hands of the Secretary of the Basic Science Board on or before October 1, 1927, you are subject to the above penalty.

Q. What information is most commonly missing from the application blank?

A. The date and number of the state license. Failure to have certificate filled out by the local Clerk of Courts.

Q. Is it necessary to return the receipt received with my certificate?

A. Yes, you must return this to complete your registration.

Next examination of the Basic Science Board will be held October 4, 1927, at the University of Minnesota.

Note:—The Basic Science Board has consulted with the Attorney General before outlining their procedure for registration.

DOCTOR:—Remember, if you do not register with the Basic Science Board on or before October 1, 1927, you will submit yourself to the following penalty—You will either have to take the examination in the Basic Sciences, or you will have to show good cause why you did not file your application prior to October 1, 1927, and pay a fee of $25.00.

REGISTER TODAY

E. A. MEYERDING, M. D.,
Secretary.

CONGRESS OF MILITARY MEDICINE

Milwaukee, Wis

Mr. George Crownhart,
Editor, Wisconsin Medical Journal.

Dear George:

I have just sent the enclosed report to the Governor. I think it will be of interest to the profession.

Yours,

G. E. SEAMAN.

—

Hon. Fred Zimmerman,
Governor of Wisconsin,
Through Adjutant General Wisconsin.

My dear Governor:

I have recently returned from the meeting of the IV International Congress of Military Medicine held in Warsaw, Poland, May 30th to June 4th, 1927, to which I was designated as a delegate and Chairman of the American Delegation by the Surgeon General of the U. S. Army, and to which you honored me with credentials as State Surgeon of the Wisconsin National Guard, which credentials served a very useful and beneficial purpose. You will, I am sure, be interested in the following brief report.

The American Delegation consisted of Col. Angus McLean of Michigan, Col. David C. Hilton of Nebraska, Lt. Col. Francis Fronczak of Buffalo, N. Y., Commander Wm. S. Bainbridge of New York, and the undersigned as Chairman of the Delegation.

The first Congress was held in 1921 at Brussels on the initiative of Belgium. The second in 1923 at Rome under the patronage of the Italian government. The third in Paris on the initiative of the French, and this year Poland took the lead and organized and entertained the Congress.

Because of the situation of the Capitol of Poland in the heart of central Europe, and because of the very great interest Poland has for all questions affecting the health of armies and civil populations, and the whole field of military and social medicine, the meeting was most interesting and productive.

The arrangements for the meeting and the hospitality of the government and people of Poland to all who attended the Congress, representing forty nations, was all that could be desired.

The purpose of the Congress is to study and report upon the medical and surgical questions growing out of the great war, and to secure to the people of the world the full benefits of all the knowledge gained by the war which would now, and in the future, save life and limb, not only in armies but in civil populations.

This Congress discussed thoroughly the following questions:

1. Evacuation of the wounded in war.
2. Treatment of head wounds and their sequelae.
3. The Cause and Prevention of Influenza.
4. The Arsaphenomines.

   (In the Treatment of Syphilis of the Nervous System.)

Certain very definite conclusions were reached on all the above questions, when the combined expression of distin-

guished medical men will be communicated to all the nations.

The next Congress will be held in London in 1929 on invitation of the British government, where the following questions will be discussed and reported upon:

1. Evacuation by water and air.
   Liason of medical services of the Army and Navy—Great Britain and France.
2. Tropical fevers of short duration, Great Britain and Netherlands.
3. Blood vessel wounds and their sequelae. Great Britain and Belgium.
4. Physical and chemical analysis of glassware and the articles made of rubber utilized in the Sanitary Service. Great Britain and Spain.
5. Condition of teeth and the physical aptitude for different military services. Great Britain and Cuba.

It was decided at the meeting to found an International Bulletin in the French and English languages for the dissemination of information relative to all matters discussed at the Congresses.

The Congress, I am sure, serves a very important purpose not only as a clearing house of valuable information of importance to armies and to all the people of the world, but it acts as a center for the development and promotion of friendly international relationships. The physical and mental health of people is international and the realm of medicine also international in scope and interests. Science is not circumscribed by national boundaries. The welfare of the people of America is vitally concerned in the knowledge of the best methods of handling the physical and mental wreckage of war, as well as the existence of communicable disease whether in Europe, Asia, Africa or America.

Such Congresses as the one under discussion deserve and must have the support of all the nations in the promotion of the welfare of mankind through the application of the best methods of military and social medicine.

GILBERT E. SEAMAN,
Colonel M. C.

MATERNITY HOME SITUATION

Fond du Lac, Wis.,
August 9, 1927.

Mr. Geo. Crownhart,
Mng. Editor, Wisconsin Medical Journal,
Milwaukee, Wis.

My dear Mr. Crownhart:

I feel that I should tell you and through you the doctors that I do not know what is being done in other maternity homes, but I do know that we make absolutely no charges for anything but actual service rendered. We do not claim to conduct a charitable institution, but we have never refused to help a worthy, clean girl because she was short of money. No charge has been made to help a girl find a home for her baby, nor do the foster parents pay for the privilege of adopting a baby. It is a part of our obligation to a girl entering our home, to protect her from publicity and keep her secret, but no fee is required for the help. We give value received for every dollar paid to us. Our food is of the best and there is an abundance of it. Everything is done to make the girls happy and contented during the waiting period. Every dollar over and above the actual cost of maintaining our home has been put back into the work up to the present date and we hope to continue to do this until we have a fully equipped modern and appreciated maternity home. We have no wish to build up a large institution. We do not wish to be always in the eyes of the public. We display no sign. Our only advertisement is in the Wisconsin Medical Journal. Our ambition is to protect the good, clean girls from the gossip that condemns them to slights and snubs that kill the efforts to live a respectable life.

Sincerely yours,
LILLIAN B. FISHER.

"The Manse,"
505 East Division Street.
Fond du Lac, Wisconsin.

More than 1,500,000 people of Wisconsin will soon have to file with the secretary of state a physical description of themselves. The law provides that after January 1st every person who operates an automobile in Wisconsin must have a drivers' license. This applies to each individual, son or daughter of the owner of the car, and every person who drives on the Wisconsin roads, whether he owns the car or not. Owners of cars receive their licenses free. All others must pay twenty-five cents for a license. Under this law a man's wife would have to obtain a license and pay for it, if the ownership of the car is in her husband's name. A full physical description must be filed with each application; age, color of hair, weight, height, color of eyes and other details. Secretary Dammann estimates that one million and a half people will have to register, and plans are now being made to hire a large office force to handle the applications. The law permits licenses to be revoked for reckless driving, intoxication and other road law violations.

* * *

That health officers in eight of 144 Wisconsin cities receive salaries above $3,000 a year appears in a report issued by the municipal information bureau of the University of Wisconsin Extension division. Milwaukee pays $7,500; Madison is next with $5,850; Racine, $4,800; West Allis, $4,000; Kenosha, $3,800; Beloit, $3,600; Green Bay, $3,150; Oshkosh, $3,120.

Health officers in the following five cities are paid from $2,000 to $3,000: Janesville, La Crosse, Sheboygan, Superior and Wausau. The salary scale in four others

is from $1,000 to $2,000: Appleton, Eau Claire, Fond du Lac and Wauwatosa.

* * *

Giving a prisoner who is married, temperate, from a rural community and a first offender against the law, the parole system in Wisconsin has much better than an even chance to restore one of society's outcasts to a normal, law-abiding life, according to a study of state records made under the direction of Prof. J. L. Gillin. It was found that after a lapse of some seven years from the date of parole, twenty-eight of thirty-five married men have beaten back to a useful career, while only eleven of seventeen single men and nine of thirteen classified as separated, divorced or widowers are successful.

* * *

Immediate registration of all drug stores in the state is required by law, according to a recent decision of Attorney-General John W. Reynolds interpreting the state law of 1927 which outlines registration requirements for pharmacies in Wisconsin.

Attorney-General Reynolds' interpretation of the statute was in reply to the recent query of G. V. Kradwell, Racine, president of the State Board of Pharmacy, who was in doubt as to whether state druggists are to register immediately or wait until next year.

The statute in question explicitly states that all druggists must register on June 1, and that they shall register each year thereafter on that date, paying a registration fee of $1. As the law was to have become effective the day after publication, it is in effect now, as official publication took place on July 30, 1927.

* * *

Moneys belonging to the state trust funds cannot be loaned to the University of Wisconsin Building Corporation to help finance the Union Memorial building the attorney-general ruled in an opinion given to the commissioners of public lands.

Moneys belonging to state trust funds may be loaned by the commissioners of public lands only to those municipalities designated in the statutes, and none other, the opinion stated.

* * *

The 1927 session of the legislature appropriated $187,937.02 more out of the conservation funds for the next two years than there will come to that fund from its several incomes the new conservation commission has announced.

Because following the legislative program would entail this deficit the conservation commission has drawn up a new budget which would keep expenditures within income.

The figures presented by the commission indicate the possibility of a first year deficit of $37,519.09, although there is a balance of $481,677.74 available in the fund now and the estimated income for the first year is $463,250.

The commission estimates that $527,709.08 would be available for the second year, while the legislative appropriations for that year total $715,707, bringing a deficit of nearly $188,000 by June 1, 1929, if all the legislative demands were carried out.

Phillips Foster Greene, recently assistant professor of surgery at the Yale-in-China Medical School, Chang-Sha, China, has been appointed associate professor of surgery in the University of Wisconsin Medical School.

Dr. Greene is a graduate of the Harvard Medical school, and has served as surgical interne at St. Luke's Hospital, New York City, as resident in St. Mary's Hospital, New York City, and as surgeon of the American hospital and instructor in surgery at Constantinople college (Constantinople, Turkey), besides having had four years of experience at the Yale-in-China hospital and medical school.

* * *

With the signing of a bill passed by the 1927 session of the legislature almost unanimously providing an appropriation to the Highway Department of $100,000 from motor vehicle license fees with which to pay the state's share of the apportionable cost of grade crossing improvements, it is believed that Wisconsin has made a vigorous start in a campaign to force the gradual elimination of the grade crossing hazard on the main traveled highways in the state.

There are about 9,000 grade crossings in Wisconsin, about one-tenth of these being on the state trunk and federal highway systems. The numbered and marked roads carry a very high percentage of the total motor traffic, some of these reaching a traffic density of 15,000 car movements per day. It is an accepted fact that the liability of accident at a railroad crossing is dependent upon the number of train and automobile movements combined.

* * *

A real estate agent cannot collect for his services in buying or selling real estate unless he has a written contract with his client, the supreme court held in reversing the decision of the county court of Chippewa county in the case of Walter L. Hale and William N. Herbert against Rude Kreisel, E. O. Wright, B. F. Crane.

The court announced that it over-ruled a previous decision (Seifert vs. Dirk) in so far as it holds that one rendering services in buying and selling real estate can collect commissions when there is no written contract.

* * *

By a three to three decision the supreme court has upheld the conviction of J. W. Morse, Grant county, for drunkenness in a public place. The court also upheld the lower court contention that a barn dance for friends on a farm where no admission is charged constituted a public function.

There was no dispute over the condition Morse was in, according to the court opinion, and the question for determination was whether the barn dance was a public function where a person might be subject to arrest. The lower court held it was and the supreme court by its tie decision upheld this contention.

* * *

The Wisconsin Anti-Lottery law is violated by a scheme which gives to each purchaser of merchandise a ticket with a number and one of which number is entitled to an article of value, the lucky number to be determined

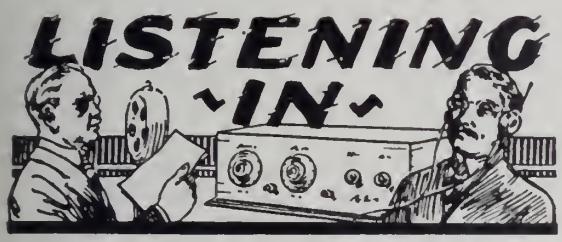
on a later date by a drawing, according to an opinion rendered by the attorney-general.

The opinion was requested by Lloyd D. Smith, district attorney of Waupaca county, in regard to a drawing on an automobile held in conjunction with the Waupaca county fair. Tickets have been sold to merchants by the fair association for ½ cent a piece, according to the district attorney, and given by the merchants with every $1 purchase.

* * *

Lobbyists far outnumbered Wisconsin legislators during the last session. The secretary of state's office listed 458 who sought to influence legislation, while 133 elected representatives worried over their official problems. This list is not complete, as private citizens and members of state departments who appeared for and against certain proposed laws do not register.

All lobbyists, particularly those who represented commercial organizations, were required to file statements of expenses with the secretary, and these are now being checked.



A High Compliment

With upwards of 200 daily and weekly newspapers in this state now using the weekly press release of the State Society, this service has just received a high compliment at the hands of Dr. John M. Dodson, Bureau of Health and Public Instruction of the American Medical Association. Dr. Dodson's statement follows:

"I have just been reading your release to the press, dated August 31, having to do with the dangers of foreign bodies in the air passages. I might say that I read all of your releases with a great deal of interest. It seems to me that you have got the idea of clearness, simple language, brevity and the selection of timely and important topics better than most any other organization I know."

Another From Michigan

"The Wisconsin State Medical Society holds its 86th annual meeting at Eau Claire on September 21st, 22nd and 23rd. We are always interested in Wisconsin's meetings for they always reflect progressive steps in organizational activity and scientific instruction. But we bet that there are a lot of Wisconsin doctors who fail to appreciate their State Society and neglect to attend. Some day they will recognize what they owe to their State Society and if they are men at heart they will make amends—but why not awaken today? Why wait till many golden opportunities are past? The same applies to Michigan."—Michigan Medical Journal, August, 1927.

Is He a Member?

The question of membership in the county and state society seems to be one of increasing importance to industrial firms, the U. S. Civil Service Commission, malpractice insurance companies and others who employ physicians. No week passes that your Secretary is not called upon to answer this question, often many times. Membership in your county medical society is a reference that is always acceptable and more and more often—required.

One on George

Your Secretary recently was called upon to publish a postcard notice of a coming district meeting. After much biting of the pen handle an especially attractive card was the result.

In attending the meeting, however, he found that the majority had gone to the waste-basket unread. The comment—"I thought it was another—ad."

Moral: Red ink on a postcard does not insure its being read.

Must Be Licensed

That those who use the x-ray to diagnose for compensation must be licensed in this state was the ruling of the Attorney General last month. The ruling follows:

You submit the following question: Can a graduate chiropractor intending to confine himself exclusively to x-ray work and the interpretation of x-ray pictures, and to make other findings by the use of an instrument, viz: a neurocalometer, practice without a license?

There is no statutory provision regulating the practice of x-ray work specifically. Sec. 147.01, sub-sec. (a) provides:

"To 'treat the sick' is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts for compensation, direct or indirect, or in the expectation thereof."

Sec. 147.02 provides that "no person shall treat, or attempt to treat, the sick unless he shall have a certificate of registration in the basic sciences, and shall have recorded the same with the county clerk in the manner provided in section 147.14, and shall have complied with all other requirements of law."

If the use of the x-ray is for the purpose of determining a prescription and diagnosing the case it is in violation of our statute, unless the person has a certificate of registration in the basic sciences and is otherwise licensed to heal the sick.

Source of Complaints

In the past few weeks your Secretary has personally investigated several cases at the Wisconsin General Hospital upon request of members. The typical complaint read that Mr. Blank was a patient of his but now he was at Madison on the "can pay $5 a day for hospital expense but physician's fee would be a hardship" basis. The family physician wrote to say that he had not sent the patient and "how come."

Each case investigated disclosed the proper letter from another physician. This indicates that one of two things may occur. Either the patient may have changed his physician or that he has left the family physician where he knows that no such letter can honestly be secured to gain the letter from one who knows his financial condition less well. In the latter instance a physician

would be the unwitting means of depriving the profession of just fees and foisting upon the hospital a patient that did not belong there to the possible exclusion of a worthy case.

Physicians asked for letters from patients not known to them will do well to make sure that the requests are worthy. The local banker generally knows.

SOCIETY RECORDS

New Members

Terry, R. E., Cuba City.
Moon, J. F., Baraboo.
Haag, A. F., Eau Claire.
Haug, J. F., 4415 North Ave., Milwaukee.

Changes in Address

Bigler, J. A., La Crosse, to 401 Fullerton Parkway, Apt. 1402, Chicago.

Eisenberg, P. J., 521 Wisconsin Ave., to 412 Century Bldg., Milwaukee.

Eisenberg, J. J., 521 Wisconsin Ave., to 412 Century Bldg., Milwaukee.

Bassuener, R. O., Milwaukee, to Sheboygan Falls.

Hanko, Mary E., Lime Ridge, to 584 Senator St., Brooklyn, N. Y.

Darling, W. S., 221 Wisconsin Ave., to 105 Wells St., Milwaukee.

Darling, F. E., 221 Wisconsin Ave., to 105 Wells St., Milwaukee.

Walker, L. J., Wykoff, Minn., to 413 Goldsmith Bldg., Milwaukee.

Gibson, A. H., Milwaukee, to 106 Monger Bldg., Elkhart, Ind.

Society Cannot Give

That the State Board of Medical Examiners is without legislative authority to receive or solicit funds from the State Medical Society for the purposes of law enforcement was the ruling made by the Attorney General of the State to Dr. Robert E. Flynn, Secretary of the Board, just prior to the 86th Annual Meeting of the State Medical Society.

The question arose nearly a year ago when the Board presented its financial situation to the Council of the State Society. It was then denied by the Council on the basis of a legal opinion from the Society's counsel holding that the policy involved was questionable if not illegal. Subsequently the Board expended its own surplus in the employment of a special investigator in the hopes that further funds might be appropriated under a bill in the legislature. The bill was later vetoed by the Governor which again raised the question of securing funds from the State Medical Society.

The opinion of the Attorney General follows:

September 17, 1927.

Robert E. Flynn, M. D., Sec'y,
Wisconsin State Board of Medical Examiners,
315 State Bank Building,
La Crosse, Wis.

Dear Sir:

In your letter of September 2nd you wish to be advised whether the state medical society could legally furnish you with the necessary money to proceed with your "enforcement program" which program has been interrupted due to the failure of your appropriation of ten thousand dollars receiving the governor's approval. You also wish to know whether there has been a precedent for this sort of procedure and you wish an expression from the attorney general as to whether it is good policy for your board to seek such funds from your state medical society.

The state board of medical examiners has no power except as expressly or by inference conferred upon it by statute. With respect to the powers that state boards and commissions have, our court in Monroe vs. Railroad Commission, 170 Wis. 180, on page 187, said:

> "The *Railroad Commission* being a tribunal of purely statutory creation, its power and jurisdiction must be found within the four corners of the statutes creating it, * * *"

The same principle is applicable to the state board of medical examiners.

Subsection (6) of section 147.13 gives the board the power to investigate complaints of violations of chapter 147 which deals with treating the sick. It gives the board the power to "notify prosecuting officers, institute prosecution, * * *". Nowhere in this chapter has the board of medical examiners been given authority to receive money in the manner you have under consideration. Until you have received legislative authority or permission therefor, you are without authority to receive or solicit the funds in question.

With respect to your question as to policy, you are informed that this department passes only on questions of law and not on questions of policy. Whether it may be good policy or bad to seek the necessary authority from the legislature so that you may receive or solicit funds from a source other than an appropriation by the legislature, is for your board to determine.

Very truly yours,
FRANK W. KUEHL,
Assistant Attorney General.

FWK:MTS
Approved:
John W. Reynolds,
Attorney General.

CAPTION: Constitutional Law, State Board of Medical Examiners. Gifts. The state board of medical examiners is without legislative authority to receive by gift, money from the state medical society for a purpose authorized by law.

Governor Vetoes Bill

As the seventh month of the legislative session opened in August, Governor Zimmerman returned to the senate, without his approval, substitute bill 156-S providing for the abolition of a lay jury in cases under the statute governing commitment of the insane and calling for abolishment of the $4.00 limitation of physician's fees in such instances. The bill was opposed by the Publications Committee of the Christian Science Church. The substitute bill, prepared in conference by the State Medical Society and others interested in this subject, provided:

Upon the original hearing the judge acts upon the report of the examining physicians, with the right in any person in interest to cross-examine and to offer evidence.

Upon a petition for reexamination three physicians examine and report, and the other procedure is the same as upon the original petition for commitment.

A further important feature of this bill is in provisions for carrying out of the plan of bill No. 550-S, suggested by the Board of Control, for a period of observation by the examining physicians, if necessary. One of these provisions repeals the present $4.00 limitation on the fee for examining physicians and provides that they shall be paid such compensation and expenses as are fixed by the judge.

The governor's veto follows:

"There are a number of objections to the changes proposed in this bill, but the primary objection is the one repealing section 51.03 which provides a jury trial for one alleged to be insane.

"While the bill still provides that the judge may commit the patient, he will be guided by the report of the three physicians who are making the investigation and who are acting in place of the jury.

"The constitutional provision that a man shall have the right of a trial by jury has ever been held sacred in this state, and while not absolute in this case it strikes me that in the case of one alleged to be insane every possible protection should be given to prevent injustice.

"For this reason, the bill is objectionable, and is returned without my approval."

Medical Examiners License Many Following June-July Meeting; Lists and Questions Announced

Licensed by examination in medicine and surgery

Melvin Dishmaker, Rush Medical College, Algoma, Wisconsin.

Norbert Enzer, McGill University, Mt. Sinai Hospital, Milwaukee Wisconsin.

Earl Elvin Evenson, Northwestern University Medical School, Wittenberg, Wisconsin.

Jacob Fine, University of Toronto, Mt. Sinai Hospital, Milwaukee, Wisconsin.

John Freedman, University of Michigan, Mt. Sinai Hospital, Milwaukee, Wisconsin.

Edward O. Gertenbach, Northwestern University Medical School, 1801 N. Wisconsin St., Racine, Wisconsin.

Harry V. Gibson, Washington University Medical School, Wis. General Hospital, Madison, Wisconsin.

Hubert F. Harman, University of Illinois, Sparta, Wisconsin.

Isaac Josefsberg, University of Vienna Medical Faculty, 1815 Wis. Ave., Milwaukee, Wisconsin.

Albert H. Lahmann, Johns Hopkins Hospital, 650 Hi-Mount Blvd., Milwaukee, Wisconsin.

Ben Lieberman, University of Wisconsin, University of Illinois, 624 10th St., Milwaukee, Wisconsin.

Henry Luidens, University of Wisconsin, Rush Medical College, Sturgeon Bay, Wisconsin.

Herman J. May, Marquette University, Milwaukee County Hospital, Milwaukee, Wisconsin.

Alice Outhouse, University of Pennsylvania, Madison, Wisconsin, R. No. 6.

Vincent J. Sutch, University of Illinois, 11333 Forest Avenue, Chicago, Illinois.

Gustav Zechel, German University of Prague, 2354 S. Albany Avenue, Chicago, Illinois.

Licensed in Osteopathy and Surgery by examination

Harriet G. Amundsen, Kirksville College of Osteopathy, 424 E. Washington St., Monroe, Wisconsin.

Walter B. Damm, Des Moines Still College of Osteopathy, 921 E. Water St., Austin, Minnesota.

Ralph E. Davis, Des Moines Still College of Osteopathy, 542 S. Dearborn St., Chicago, Illinois.

Carl H. Gloeckler, Chicago College of Osteopathy, Portage, Wisconsin.

Christian R. Sannes, Chicago College of Osteopathy, 317 State St., Madison, Wisconsin.

Lafayette D. Thompson, Kirksville College of Osteopathy, 512 Liberty Cent. Trust Bldg., St. Louis, Missouri.

Licensed in Medicine and Surgery by Reciprocity

Harold F. Beglinzer, Illinois, 394 Merritt Street, Oshkosh, Wisconsin.

William S. Beyer, Minnesota, Wisconsin General Hospital, Madison, Wisconsin.

Albert W. Bryan, Iowa, Care of Jackson Clinic, Madison, Wisconsin.

Cornelius J. Buckley, Massachusetts, Milwaukee Hospital for Mental Diseases, Wauwatosa, Wisconsin.

William Burst, Illinois, Mendota, Wisconsin.

Roy E. Bushong, Ohio, 875 Sherman Boulevard, Milwaukee.

Joseph W. Gale, Missouri, University Club, Madison, Wisconsin.

Harry C. Gebhart, Illinois, Indian Mound Reservation, Oconomowoc, Wisconsin.

Will B. Gnagi, Jr., Missouri, Monroe, Wisconsin.

Harold J. Heath, Illinois, Bloomington, Wisconsin.

Elgie M. Houghton, Illinois, Victoria, Illinois.

Robert J. Hyslop, Illinois, Herrin, Illinois.

John E. Komoroske, Indiana, Mishicott, Wisconsin, Route No. 1, Care of Midelfart Clinic.

Julian Y. Malone, No. Carolina, Eau Claire, Wisconsin.

Charles E. J. McJilton, Minnesota, 153 W. Ave. N., St. Paul, Minnesota.

David Thornton Proctor, Illinois, 7100 3rd Avenue, Kenosha, Wisconsin.

Martin Sansby, Minnesota, 972 Goodrich Avenue, St. Paul, Minnesota.

John T. Stephenson, Georgia, Omro, Wisconsin.

Alvin M. Stober, Illinois, 2454 N. Kidzii Boulevard, Green, Iowa.

Willard C. Sumner, Illinois, Edgerton, Wisconsin.

Harry Tabachnick, Maine, Shorewood Hospital, Milwaukee, Wisconsin.

Robert Emmett Terry, Missouri, Cuba City, Wisconsin.

Joseph Travenick, Jr., Tennessee, Care of Dr. F. J. Ploudke, Lowry Building, St. Paul, Minnesota.

Harry R. Warner, Minnesota, Wisconsin General Hospital, Madison, Wisconsin.

Linton Gilmore Weed, Illinois, Phelps, Wisconsin.

Licensed in Osteopathy and Surgery by Reciprocity

James A. Baird, Missouri, Wittenberg, Wisconsin.

Cyrus P. Knowlton, Minnesota, Waterloo, Wisconsin.

Osteopaths Licensed by Examination in Surgery

Chester W. Parish, Los Angeles College of Osteopathy, Whitewater, Wisconsin.

Kirk W. Shipman, American School of Osteopathy, Evansville, Wisconsin.

Licensed by Examination in Chiropody

August Bendlin, Illinois College of Chiropody, 423 11th Avenue, Milwaukee.

Jacob R. Bennett, Illinois College of Chiropody, 216 E. Russell St., Monroe, Wisconsin.

Walter Blumer, Illinois College of Chiropody. 923 Airdrie Place, Chicago, Illinois.

Louis C. Boyd, Illinois School of Chiropody, 605 Gilmore Street, Marinette, Wisconsin.

William A. Killa, Illinois College of Chiropody, 1327 N. Clark Street, Chicago, Illinois.

Edward H. Mauer, Illinois College of Chiropody, 1327 N. Clark Street, Chicago, Illinois.

Robert Regez, Illinois College of Chiropody, 1327 N. Clark Street, Chicago, Illinois.

John Schmidt, Illinois College of Chiropody, 106 W. Washington Street, Monroe, Wisconsin.

Licensed by Examination in Massage and Hydrotherapy

Alfred Hotz, 1316 N. 14th Street, Sheboygan, Wisconsin.

Maria Klehr, Course in Massage, Breslau, Germany, 891 8th Street, Milwaukee, Wisconsin.

Monroe Lundy, Kellerg Institute, Beloit, Wisconsin.

John Wagner, 1114 Vine Street, Milwaukee, Wisconsin.

Ida Zeimet, 618 Wisconsin Avenue, Apt. 9, Milwaukee, Wisconsin.

Licensed by Examination in Midwifery

Mrs. Paula Daum, Provincial Hebammer Anstalt, 2311 67th Street, Kenosha, Wisconsin.

PRINCIPLES AND PRACTICE OF MEDICINE

J. Gurney Taylor, M. D., Examiner

Answer first four (4) questions, and any three (3)

questions may be selected from the remaining. Seven (7) must be answered.

1. Outline symptoms, diagnosis and treatment of facial erysipelas.
2. State symptoms, differential diagnosis and treatment of mitral insufficiency.
3. Differentiate (a) renal colic, (b) gall stone colic, and (c) acute appendicitis.
4. Give differential diagnosis of left pleural effusion and croupous pneumonia involving left lower lobe, with outline of treatment of the former.
5. State symptoms and physical findings present in a case of advanced chronic interstitial nephritis. Giving treatment for uremia.
6. Outline symptoms, diagnosis and treatment of influenza.
7. Differentiate cerebral hemorrhage from alcoholism.
8. Discuss arthritis deformans, character of deformities, symptoms and treatment.
9. Give symptoms and differential diagnosis of gastric carcinoma and gastric ulcer.
10. Tabies dorsalis: Discuss (a) etiology, (b) symptoms and course, (c) treatment.

PEDIATRICS

J. Gurney Taylor, M. D., Examiner

(Answer all 5 questions)

1. Whooping cough: Discuss (a) etiology, (b) symptoms and course, (c) complications and sequelae, (d) treatment.
2. Discuss the period of communicability of: measles, scarlet fever, mumps, diphtheria and small pox.
3. Premature infant: Discuss feeding and general care.
4. Scurvy: Give etiology, symptoms and prevention.
5. What symptoms are produced by enlargement of thymus; state procedures used in diagnosis of same.

ANATOMY

Wilbur N. Linn, M. D., Examiner

1. Give the course, relations and structure of the ureter. Note difference in male and female.
2. Mention and describe the salivary glands.
3. Describe the renal blood circulation.
4. (a) Describe and give the anatomical relation of the appendix veriformis.
   (b) Give location of the intercostal arteries.
   (c) Origin of the intercostal nerves.
5. Name ten principal muscles which keep the body erect.
6. Describe the sympathetic nerve, naming and locating the principal ganglia.
7. Describe the bones of the ankle. Make diagram.
8. Give surgical anatomy of femoral hernia.

EYE, EAR, NOSE AND THROAT

Wilbur N. Linn, M. D., Examiner

1. (a) Describe the eyeball and give its parts.
   (b) Give indications for removal of the same, following a penetrating wound.
2. (a) Give indications for paracentesis of the ear drum.
   (b) The location of the cut and after treatment.
   (c) Briefly describe the eustachian and give functions.
3. Describe the alfactory apparatus. What part of the above is the seat of smell. What are the causes and results of mouth breathing.
4. Describe the esophagus:
   (a) Location.
   (b) Dimensions.
   (c) Arterial and nerve supply.

PHYSIOLOGY

J. B. Brewer, M. D., Examiner

1. Give the normal heart sounds and cause of each.
2. Where is the bile formed?
3. Give mechanism of resperation and how controlled.
4. Does pepsin suffer any change when acting?
5. What is the olivary body?
6. What is the function of the epiglottis in regard to sound?
7. Describe the formation of the ovule in the ovary.
8. In what way are the salivary glands, the pancreas and the liver developed?

MEDICAL JURISPRUDENCE

J. B. Brewer, M. D., Examiner

1. Give hypostatic lung test.

DIETETICS

J. B. Brewer, M. D., Examiner

1. What are the characteristics of good butter?
2. Why is meat such an important article of food?

OBSTETRICS

Edith Haigh-Stevens, M. D., Examiner

(Write on 7 questions)

Use separate book

1. Tell briefly but definitely, the physiological evolution of the uterus, during pregnancy.
2. What promises would you make the patient concerning involution after labor?
3. Give probable and presumptive signs of pregnancy.
4. Describe simulations of pregnancy.
5. Differentiate pregnancy nephrosis from chronic nephritis.
6. Give ten "danger signals" of pregnancy.
7. Discuss mastitis.
8. Why and when do you give anasthesia during labor? Explain synergistic analgesia in obstetrics.

GYNECOLOGY

Edith Haigh-Stevens, M. D., Examiner

(Write on 4 questions)

Use separate book

1. How detect and treat gonorrhea in the female?
2. Give the "after-coming" results of gonorrhea and syphilis—to the female organism by approximating percentage of (1) abortions; (2) infantile mortality; (3) degenerates; (4) sterility; (5) gynecologic diseases; (6) blindness.
3. Give your knowledge from training or experience of the removal of uterine myomata; explaining conditions, which call for a decision between total and subtotal hysterectomy.
4. Tell what you know of the relationship between the thyroid and ovarian glands.
5. Possibilities of a fluctuating mass in right lumbar region; Name at least ten and give brief reason for diagnosis.

MATERIA MEDICA

T. J. Sheehy, M. D., Examiner

1. Mention three commonly used miotics.
2. (a) Name five official preparations of mercury.
   (b) Name four alkaloids of opium.
3. Name the official bromides.
4. How do strophanthus and digitalis differ in physiologic action?
5. How is amyl-nitrate administered and for what purpose?
6. How is action of opium modified by (a) age, (b) sex, (c) habit, (d) idiosyncrasy?
7. Define hematics. Mention two principal hematics.
8. What class of acids would you use to acidify alkaline urine?

TOXICOLOGY

T. J. Sheehy, M. D., Examiner

1. Discuss the symptoms of cocain poisoning.
2. What is the antidote of strychnine?
3. Mention three drugs the use of any one of which may cause skin eruptions.

SURGERY

Robert E. Flynn, M. D., Examiner

(Answer any 8 questions)

1. Given a case of diabetic gangrene of a toe.
   (a) Give technique of amputation and your judgment of how and where to amputate.
   (b) Give postoperative treatment.
2. Differentiate: Carcinoma of Pancreas, Cholelithiasis and subphrenic abscess.
3. Give surgical treatment of advanced tuberculosis of the knee.
4. (a) What factors would you consider in a non-union of fracture of the femur?
   (b) Give brief outline of treatment.
5. (a) How would you treat an ischiorectal abscess?
   (b) What are its causes and complications?
6. What are the symptoms and your basis for surgical procedure in a suspected case of ruptured ectopic?
7. How would you treat an empyema in a child 8 years old?
8. Differentiate between a direct and indirect inguinal hernia? Between an incarcerated and strangulated hernia?
9. How would you diagnose an early carcinoma of the breast? Outline your treatment for same.
10. Given a case of suspected stone in kidney or ureter. Give method of diagnosis and your treatment for nephrolithiasis.

CHEMISTRY

R. C. Rodecker, M. D., Examiner

1. Describe Reinsch's test for arsenic.
2. Description of an extemporaneous antidote of nitrate of silver poisoning: How does it act?
3. Name a simple test for contents washed from the stomach in suspected carbolic acid poisoning.

PATHOLOGY

R. C. Rodecker, M. D., Examiner

1. Discuss briefly the causes and constitution of gall stones.
2. Define and discuss very briefly hypertrophy. Discuss briefly an organ the seat of hypertrophy.
3. What is meant by focal infection? Give illustrations of sites of occurrences and possible results.
4. What types of inflammation may the tubercle bacillus produce?
5. What visceral lesions found at autopsy signify old syphilis?
6. Describe the pathology of chronic myocardial degeneration: Explain its relation to arrythmia.
7. Differential diagnosis of carcinoma and sarcoma.
8. Brief description of liver and kidney: autopsy of eclampsia.

PHYSICAL DIAGNOSIS

E. C. Murphy, D. O., Examiner

(Answer only three)

1. Give the physical signs of pleuritic effusion?
2. What are the physical signs of stenosis of the mitral valve?
3. What are the clinical features of cerebrospinal meningitis?
4. What are the diagnostic signs of retropharyngeal abscess?

NEUROLOGY

E. C. Murphy, D. O., Examiner

(Answer only three)

1. What is the significance of the patellar reflex as a sign of disease?
2. Give the symptoms resulting from paralysis of the phrenic nerve.
3. Give causes, symptoms and prognosis of Bell's palsy.
4. Describe aphasia.

HYGIENE

E. C. Murphy, D. O., Examiner

(Answer both)

1. How should a thorough inspection of milk be conducted?
2. What rules in public health administration should be promulgated to prevent the spread of pulmonary tuberculosis?

BASIC SCIENCE EXAMINATION

Milwaukee, Wis.

June 27, 1927.

DIAGNOSIS

1. Give the differential diagnosis between epilepsy and hysteria.
2. Differentiate between pleurisy with effusion and lobar pneumonia.
3. Give the chief diagnostic points of scarlet fever, diphtheria, measles, rubella, small pox and chicken pox.
4. Give the symptoms of influenza.
5. What is the Schick test? What is immunization?
6. Give test of sputum for tuberculosis.
7. Differentiate between: uremia, typhoid fever.

ANATOMY

1. (a) Name the muscles, and their nerve supply, producing inversion (medial rotation) and eversion (lateral rotation) at Chopart's joint.
   (b) What is the action and the nerve supply of the lumbrical and interosseous muscles of the hand?

2. (a) Name the vascular structures forming the Circle of Willis.
   (b) What is the distribution of the coeliac artery?
3. Name the chief tributaries and the final discharge of the following veins:
   (a) Portal. (b) Jugular. (c) Azygos
4. Name the structures and their relationship encountered in descending upon a femoral hernia.
5. Name and make a sketch of the layers of the skin.
6. (a) Name the bones comprising the wall of the orbit.
   (b) Name the foramina through which the respective cranial nerves make their exit from the cranium.
7. Name and make a cross section drawing of the fiber tracts and nuclei found in a cross section of the spinal cord at the level of the first lumbar segment.
8. What is the exact origin and distribution of the following nerves:
   (a) Phrenic. (b) Glossopharyngeal.
   (c) Chorda Tympani.
9. Describe the origin, tributaries and the course of the thoracic duct.
10. Define and give the significance of the following:
   (a) Valve of Thebesius.
   (b) Aschoff bodies.
   (c) Schlemm's canal.
   (d) Islands of Langerhans.
   (e) Carotid body.
   (f) Choroid plexus.
   (g) Cysterna chyli.
   (h) Ducts of Skene.
   (i) Glisson's capsule.
   (j) Ducts of Rivinus.

PATHOLOGY

1. Define:
   (a) Pathology.
   (b) Abscess.
   (c) Phlegmon.
   (d) Cyst.
   (e) Atrophy.
   (f) Carcinoma.
   (g) Sarcoma.
   (h) Infection.
   (i) Necrosis.
   (j) Degeneration.
2. Discuss the cause of fever.
3. What are the changes in the blood in the various kinds of general anaemia?
4. Name the symptoms or signs of inflammation and give the changes in the tissue that produce them.
5. What pathological changes may cause violent hemmorrhage from the nose or mouth, i. e., hemoptysis, hematemesis?
6. What symptoms may result from a fracture of the skull, and discuss the pathological changes that produce them?

PHYSIOLOGY

1. (a) Name the chief constituents of bile.
   (b) What are the functions of bile?
2. (a) State the factors that are responsible for maintainence of arterial blood pressure.
   (b) What forces determine the return of venous blood to the heart?
3. (a) What are the chief functions of the kidney?
   (b) Discuss briefly glomerular filtration.
4. What is lymph? Where is it formed? What are its functions?
5. (a) Give a normal complete blood cell count.
   (b) State where each component is formed.

Foundation Fund Approved at Eau Claire Meeting; K. W. Doege of Marshfield Named President-Elect; Close to 400 Members Register

Upwards of 600 members of the State Medical Society, health officers of the state, exhibitors and guests came to Eau Claire the third week in September to attend the joint sessions of the State Medical Society and the Biennial Conference of State Health Officers. From the arrival of the first guest to the departure of the last, every facility of Eau Claire was placed at their disposal and scientific program and entertainment blended to fulfill the pre-meeting promise of a session "long to be remembered."

Two new major policies were adopted by the House of Delegates during their meetings,—approval of the recommendation by President A. W. Rogers that the Society inaugurate a Foundation Fund, and approval of a conference at Society headquarters to which executives of official and non-official health organizations will be invited for the purpose of securing a better understanding of efforts and extending proper cooperation from the Society.

Other outstanding actions of the Society include the election of K. W. Doege, Marshfield, retiring Speaker of the House of Delegates as President-Elect; the selection of Milwaukee as a place of meeting in 1928; electing to honorary membership L. H. Pelton of Waupaca, a past president of the State Society; a ceremony at the grave of the late J. V. R. Lyman, honoring him as a physician and citizen, and the election of the following councilors: J. M. Dodd, Ashland; Robert W. Blumenthal, Milwaukee; A. W. Rogers, Oconomowoc, and Frank W. Pope, Racine.

FOUNDATION FUND

Speaking before the House of Delegates President Rogers declared that the rapid strides of progress taken by the Society had but pointed the way to new fields of efforts in future years that would be increasingly profitable to the individual members and the Society. He recited the fact that all that had now been accomplished had been done with an office staff of but a secretary

and two assistants, pointing out that more and more would the Society need additional funds for its future work. He declared that he neither advocated an increase in dues nor a solicitation of the members but rather the establishment of a Society Foundation under proper control that those who cared to, might by gift or bequest, leave to this fund monies that could be used for the future advancement of the profession. In advocating establishment of this fund, the president announced that he knew of one member that would contribute $5,000 presently and provide for an additional $20,000 in his will.

President Rogers' suggestion met with an enthusiastic reception from the House of Delegates who authorized its establishment and nominated the President, Speaker of the House of Delegates and Secretary as a committee to work out any necessary details for its actual accomplishment at the January Council meeting. Before the meeting had adjourned a second gift by will had been announced amounting to many thousand dollars.

President-elect McGovern urged authorization of a conference of health executives to be held in Milwaukee next January. This suggestion was also adopted by the House. The session will be devoted solely to statements by invited guests on the work their organizations are doing and contemplate "to ascertain possibilities for medical aid in worthy projects and to bring about eventually the close cooperation which exist among all who are interested in furthering public health."

HOUSE OF DELEGATES

Working through three sessions and with five reference committees, the House of Delegates transacted an unusual amount of business. Highlights of its sessions include:

Elections:

President-Elect—K. W. Doege, Marshfield.
Speaker, House of Delegates—A. J. McDowell, Soldiers Grove.
Vice-Speaker, House of Delegates—D. L. Dawson, Rice Lake.
Delegate, A. M. A.—Joseph F. Smith, Wausau, re-elected.
Alternate Delegate—R. E. Mitchell, Eau Claire, re-elected.
Councilor—J. M. Dodd, Ashland, re-elected.
Councilor—Robert W. Blumenthal, Milwaukee, to succeed H. E. Dearholt, resigned.
Councilor—A. W. Rogers, Oconomowoc, re-elected.
Councilor—Frank W. Pope, Racine, to succeed Gustav Windesheim, Kenosha, resigned.
Fraternal Delegate to Illinois—S. J. Seeger, Milwaukee.
Fraternal Delegate to Iowa—Wilson Cunningham, Platteville.
Fraternal Delegate to Minnesota—F. E. Butler, Menomonie.

Resolutions:

1. Asking that the State Board of Health and State Medical Society cooperate to make a study of the cause of maternal mortality over a three year period in this state.
2. Endorsing the position of the American Medical Association in requesting legislation to the end that departmental regulations of federal nature be published prior to adoption and an opportunity be given for a hearing for or against such proposed rulings before their promulgation.
3. Carrying a vote of thanks to the Eau Claire and Associated Counties Medical Society for their cordial reception, arrangements and hospitality.

Constitutional Amendments:

1. Rejected by an almost unanimous vote a proposed amendment providing that councilors should be elected in district meeting rather than being nominated by delegates in caucus from the district affected and subsequent election by the House.
2. Received an amendment to be acted upon in 1928 providing that past presidents of the State Society shall be ex-officio members of the House of Delegates.

New Business:

1. Authorized continuance of the lay educational program.
2. Ordered a second conference of county secretaries to be held in Milwaukee in January, 1928.
3. Adopted the President's proposal for a Foundation Fund.
4. Adopted the suggestion for a conference of executives of societies engaged in public health effort.
5. Commended the Board of Medical Examiners for work accomplished in the field of law enforcement and ordered the Committee on Public Policy to reintroduce in the next legislative session a bill to provide additional funds to the Board to extend the scope of the Board's efforts.
6. Ordered continued the committees on the study of the nursing problem and licensure of hospitals with instructions to report suggested legislation in detail at the 1928 meeting of the House.
7. Authorized the Secretary to publish an indexed abstract of laws and rulings affecting the medical profession.
8. Ordered the Committee on Public Policy to suggest to the next legislature the advisability of the following proposals:
    a. Optional licensure of institutions for the care of mental cases.
    b. Substitution for the lay jury in the judicial determination of sanity.
    c. Advisability of additional funds for the enforcement of laws governing who may treat the sick.

d. Present, after conference with the Board of Medical Examiners, a measure to end the licensure of itinerant practitioners of medicine and surgery in Wisconsin.

9. Adopted the recommendation of the Reference Committee on Resolutions calling for the continuance of dues for 1928 at $10.

DINNER AND SMOKER SUCCESS

Two entertainment features of the 86th Anniversary Meeting will long be remembered by those in attendance. Posing as the head waiter, Mr. Luke Barnett, Pittsburgh, (nationally known for his speciality) completely fooled the members with his clever acting. He might well be called the "Perfect Nuisance" for he was continually arousing the ire of the members by his awkward deportment, requests that they assume other seats, urging quiet and pleas for a little cooperation until the 300 members present rose in a body to urge that he be thrown out. The deception was perfect, ending in a fight with another waiter in which members rushed to separate them and calm them down. Not until then was he introduced and told how at least one member had tipped him a dollar to appease his apparent ill temper at having to serve doctors in the Elk's Club. The Club was arranged as one of the old Biergartens and a special revue entertained the members during the evening.

The Annual Dinner was at least unusual with postponement of the address of E. T. Devine, Dean of the Graduate School of American University, Washington, D. C., until the Tunney-Dempsey fight returns could be broadcast. Previous to the fight returns the President announced as guests Congressman James A. Frear and Mr. Percy Atkinson, editor of the Eau Claire Press Company. Following this Dr. H. M. Stang, chairman of the Program Committee, presented to the secretary an elaborately embellished diploma conferring upon him the degree of "Doctor of Activities."

HONORS GIVEN

On Wednseday afternoon, close to a hundred members motored to Forest Hill Cemetery where President A. W. Rogers laid a wreath on the grave of the late Dr. J. V. R. Lyman, who was President-elect of the Interstate Post Graduate Assembly at the time of his death. At the ceremony Dr. Rogers spoke of the outstanding services of Dr. Lyman to his profession and to the public.

During sessions of the House, Chairman Edward Evans of the Council announced the following honorary elections: L. H. Pelton of Waupaca and Margaret Caldwell of Waukesha.

Dr. Pelton, present at the meeting, was born in 1848 and has been in continuous practice in Wisconsin since 1876. Dr. Pelton has been a member of the State Medical Society of Wisconsin since 1874 and at one time served as its President. Dr. Pelton responded to the honor conferred on the floor of the House. Dr. Margaret Caldwell, 82, is the oldest woman physician in Wisconsin and is an honorary member of the Waukesha County Medical Society.

LADIES' ENTERTAINMENT

A distinct feature of the meeting was the elaborate entertainment accorded the visiting ladies by the wives of the members of the Eau Claire and Associated Counties Medical Society and of the Chippewa County Medical Society. On the first day of the scientific session the ladies were entertained at individual luncheons at Eau Claire homes and later motored about the city and then to Menomonie where they played bridge and had tea at the Country Club. Following the Open Meeting Wednesday evening, at which 1,200 were present, the ladies had tickets to a special performance of the State Theatre while the members were at the Smoker.

Thursday morning they drove to Chippewa Falls and had luncheon at the Northern Hotel. Special entertainment features were presented during the luncheon hour. During the afternoon they played bridge. On Friday there were a series of drives around the city ending at the Eau Claire Country Club where luncheon was served followed by bridge and golf in the afternoon.

GOLF TOURNAMENT

Members from every part of the state competed in the annual golf tournament held at the Eau Claire Country Club on the day prior to the scientific sessions. Results of the tournament announced by Chairman G. E. Curtis at the Annual Dinner follow:

President's Trophy and Gold Medal—low gross.

1. A. J. Somers, Chippewa Falls, 81.
2. Ernest Miller, Milwaukee, 83, Wool Sweater.
3. M. P. Andrews, Manitowoc, 85, Golf Bag.

Secretary's Trophy and Silver Medal—low net.

1. W. Frawley, Appleton, 83-18:65.
2. R. L. MacCornack, Whitehall, 96-24:72, Golf Shoes.
3. C. Reineck, Appleton, 96-24:72, Golf Bag.

Choice Scores, Gross, Best Nine in Eighteen.

1. F. A. Thompson, Milwaukee, 41, Cigarettes.
2. F. A. Thayer, Beloit, 43, Golf Balls.
3. B. Nylander, Ellsworth, 44, Golf Balls.

Choice Scores, Net, Best Nine in Eighteen.

1. J. J. McGovern, Milwaukee, 49-18:31, Cigars.
2. S. G. Higgins, Milwaukee, 48-15:33, Golf Balls.
3. D. G. Hugo, Oshkosh, 45-12:33, Golf Balls.

MANY REGISTER

A complete list of those registered at the Registration Booth follows:

Adams, R. W. ..... Chetek
Allen, Jessie P. ..... Beloit
Altenhofen, A. R. ..... Milwaukee
Allen, J. S. ..... Norwalk
Alley, H. C. ..... Eleva
Alvarez, R. L. ..... Galesville
Amunson, P. B. ..... Mondovi
Anderson, F. G. ..... Eau Claire
Anderson, N. P. ..... La Crosse
Armstrong, J. H. ..... New Richmond
Babcock, I. G. ..... Cumberland
Bach, E. C. ..... Milwaukee
Baird, J. C. ..... Eau Claire
Baker, G. L. ..... Rib Lake
Bannen, W. E. ..... La Crosse
Bardeen, C. R. ..... Madison
Bassuener, R. O. ..... Sheboygan Falls
Bayer, W. H. ..... Merrill
Becker, C. J. ..... Milwaukee
Beebe, C. D. ..... Sparta
Beebe, George ..... Eau Claire
Beebe, L. W. ..... Superior
Beebe, S. D. ..... Sparta
Belting, G. W. ..... Orfordville
Benton, J. L. ..... Appleton
Berglund, S. A. ..... Marinette
Betz, J. C. ..... Boscobel
Bill, B. J. ..... Genoa City
Blackburn, F. E. ..... Cassville
Blosmo, O. J. ..... Menomonie
Blumenthal, R. W. ..... Milwaukee
Blumer, Edward ..... Monticello
Boothby, E. L. ..... Hammond
Bourne, N. W. ..... Milwaukee
Boyd, C. D. ..... Kaukauna
Bradford, E. B. ..... Hudson
Braun, R. F. ..... Wausau
Breed, A. L. ..... Elmwood
Brooks, E. H. ..... Appleton
Brook, J. J. ..... Milwaukee
Brookie, R. W. ..... Pepin
Brunckhorst, F. W. ..... Hortonville
Buckland, R. H. ..... Fairwater
Bugher, C. E. ..... Ladysmith
Butler, F. E. ..... Menomonie
Carson, W. J. ..... Milwaukee
Caswell, H. O. ..... Ft. Atkinson
Chapman, V. A. ..... Milwaukee
Christensen, O. A. ..... Hawkins
Christiansen, G. ..... Galesville
Clark, J. F. W. ..... Laona
Cleary, B. L. ..... Edgerton
Coerper, E. E. ..... Fredonia
Coffey, C. J. ..... Milwaukee
Coleman, H. M. ..... Barron
Combs, C. J. ..... Oshkosh
Comstock, Elizabeth ..... Arcadia
Connell, D. R. ..... Beloit
Connell, F. Gregory ..... Oshkosh
Conway, H. P. ..... Spring Valley
Cook, F. S. ..... Eau Claire
Coon, H. M. ..... Stevens Point
Cooper, C. A. ..... Colfax
Corlett, M. S. ..... Rhinelander
Cunningham, J. N. ..... Stanley
Cunningham, R. D. ..... Cadott
Cunningham, Wilson ..... Platteville
Curl, Howard ..... Sheboygan
Curtis, G. E. ..... Eau Claire
Dallwig, E. L. ..... Milwaukee
Dana, A. C. ..... Fond du Lac
Davis, C. H. ..... Milwaukee
Dawson, D. L. ..... Rice Lake
Dearholt, H. E. ..... Milwaukee
Decker, C. O. ..... Crandon
Deicher, H. F. ..... Plymouth
Derge, H. F. ..... Eau Claire
Devine, G. C. ..... Ontario
Dieterle, J. O. ..... Milwaukee
Dietrich, L. S. ..... Medford
Dike, B. H. ..... Owen
Dodd, J. M. ..... Ashland
Doege, K. H. ..... Marshfield
Doege, K. W. ..... Marshfield
Dohearty, F. P. ..... Appleton
Dohearty, W. H. ..... Peshtigo
Domann, W. G. ..... Menomonee Falls
Duer, G. R. ..... Marinette
Echols, C. M. ..... Milwaukee
Erickson, H. C. ..... Viroqua
Evans, Edward ..... La Crosse
Fairfield, W. E. ..... Green Bay
Farr, J. F. ..... Eau Claire
Federspiel, M. N. ..... Milwaukee
Fiedler, O. A. ..... Sheboygan
Fisher, R. F. ..... Wausau
Flynn, L. H. ..... Eau Claire
Flynn, R. E. ..... La Crosse
Foley, F. P. ..... Dorchester
Fortner, W. H. ..... Bloomer
Foster, J. H. A. ..... Cornell
Fox, Paul A. ..... Beloit
Frawley, W. J. ..... Appleton
Frick, Lewis ..... Athens
Frisbie, R. L. ..... Humbird
Gaenslen, F. J. ..... Milwaukee
Gallagher, E. E. ..... La Crosse
Ganser, W. J. ..... Madison
Gates, A. J. ..... Tigerton
Gavin, S. E. ..... Fond du Lac
Gendron, A. E. ..... River Falls
Glasier, M. B. ..... Bloomington
Gleason, C. M. ..... Manitowoc
Gramling, E. H. ..... Milwaukee
Griswold, F. L. ..... Mazomanie
Griswold, G. W. ..... Alma Center
Gudex, V. A. ..... Milwauee
Guilford, H. M. ..... Madison
Gundersen, A. H. ..... La Crosse
Gundersen, G ..... La Crosse
Gundersen, S. B. ..... La Crosse
Guyton, E. A. ..... Eau Claire
Haag, A. F. ..... Eau Claire
Halgren, J. A. ..... Menomonie
Hall, S. S. ..... Minneapolis, Minn.
Halsey, R. C. ..... Lake Geneva
Hanson, L. E. ..... Holmen
Harper, C. A. ..... Madison
Harper, C. S. ..... Madison
Harper, G. C. ..... Durand
Harrington, T. L. ..... Milwaukee
Hassall, J. C. ..... Oconomowoc
Hatleberg, C. B. ..... Chippewa Falls
Haugen, A. I. ..... Stanley
Hayes, E. P. ..... Eau Claire
Hayes, E. S. ..... Eau Claire
Heising, A. F. ..... Menomonie
Hemmingsen, T. C. ..... Racine
Henika, G. W. ..... Madison
Henske, W. C. ..... Chippewa Falls
Higgins, S. G. ..... Milwaukee
Hilliard, H. G. ..... Hayward
Hodges, F. J. ..... Madison
Hoffmier, L. A. ..... Superior
Hosmer, M. S. ..... Ashland
Housley, H. W. ..... Neillsville
Howison, N. L. ..... Menomonie
Hoyer, G. C. ..... Appleton
Hoyme, G. ..... Eau Claire
Huber, G. W. ..... Minocqua
Hugo, D. G. ..... Oshkosh
Hurd, H. H. ..... Chippewa Falls
Jackson, R. H. ..... Madison
Jegi, H. A. ..... Galesville
Johnson, B. F. ..... Mondovi
Johnson, Fred ..... Eau Claire
Johnson, F. G. ..... Iron River
Johnson, H. C. ..... Bruce
Kauth, Phillip ..... Slinger
Kearns, W. M. ..... Milwaukee
Keland, H. B. ..... Racine
Kelley, J. A. ..... Chippewa Falls
Kennedy, F. H. ..... Iron Ridge
Kinsman, F. C. ..... Eau Claire
Knapp, E. J. ..... Rice Lake
Knauf, A. J. ..... Sheboygan
Knowles, W. L. M. ..... Spooner
Knutson, Oscar ..... Osseo
Krembs, F. R. ..... Stevens Point
Kristjanson, H. T. ..... Milwaukee
Krueger, Bernard ..... Cudahy
Kunny, B. ..... Baldwin
La Breck, F. A. ..... Eau Claire
Landis, R. V. ..... Appleton
Larsen, L. A. ..... Colfax
Lawrence, H. W. ..... Janesville
Leahy, J. D. ..... Park Falls
Leasum, R. N. ..... Osseo
Lemmer, G. N. ..... Spooner
Lindsay, W. T. ..... Madison
Lockhart, J. W. ..... Oshkosh
Locvenhart, A. S. ..... Madison
Long, D. T. ..... Menomonie
Loope, T. E. ..... Iola
Lotz, Oscar ..... Milwaukee

Lowe, J. W. ..... Merrillan
Lueck, G. W. ..... La Crosse
Lumsden, Wm. ..... Menomonie
Lund, S. O. ..... Cumberland
Lundmark, L. M. ..... Ladysmith
Lynch, H. M. ..... Alienton
MacArthur, D. S. ..... La Crosse
MacCollum, C. L. R. ..... Manitowoc
MacCornack, R. L. ..... Whitehall
MacKechnie, R. S. ..... Hillsboro
McCarey, A. J. ..... Green Bay
McCormick, H. ..... New Auburn
McCorkle, S. C. ..... West Allis
McDowell, A. J. ..... Soldiers Grove
McGarty, M. A. ..... La Crosse
McGill, P. G ..... Superior
McGovern, J. J. ..... Milwaukee
McGrath, E. F. ..... Appleton
McLaughlin, H. J. ..... Bloomington
McLaughlin, W. J. ..... Wrightstown
McMahon, A. E. ..... Glenwood City
McMahon, J. P. ..... Milwaukee
Maas, W. C. ..... Rio
Macauley, E. McL. ..... Wausau
Malcolm, J. J. ..... Edgar
Malloy, T. E ..... Random Lake
Marsh, R. E. ..... Madison
Marsh, J. M. ..... Elkhorn
Marshall, V. F. ..... Appleton
Mason, C. H. ..... Superior
Mason, E. L. ..... Eau Claire
Mauermann, J. F. ..... Monroe
Merrill, W. G. ..... Wisconsin Rapids
Mertens, H. G. ..... Bayfield
Meusel, Harry ..... Oshkosh
Miedling, A. E. ..... Milwaukee
Miller, E. W. ..... Milwaukee
Minahan, J. J. ..... Chilton
Minahan, J. R. ..... Green Bay
Minahan, P. R. ..... Green Bay
Mitchell, R. E. ..... Eau Claire
Monroe, W. B. ..... Monroe
Montgomery, R. B. ..... La Valle
Moore, G. E. ..... Antigo
Mork, Ole ..... Blaire
Mulvaney, F. M. ..... Marion
Murphy, F. D. ..... Milwaukee
Neidhold, C. D. ..... Appleton
Neilson, G. W. ..... Milwaukee
Nelson, A. N. ..... Clear Lake
Newton, J. E. ..... Hudson
Noyes, G. B. ..... Stone Lake
Nylander, E. G. ..... Ellsworth
O'Connor, W. F. ..... Ladysmith
O'Leary, T. J. ..... Superior
Oliver, T. J. ..... Green Bay
Olson, E. A. ..... Osseo
Palmer, J. A. ..... Arcadia
Panetti, P. A ..... Hustisford
Parke, George ..... Viola
Parker, A. S. ..... Clinton
Payne, A. L. ..... Eau Claire
Pelton, L. H. ..... Waupaca
Perry, Gentz ..... Rhinelander
Peterson, E. F. ..... Wauwatosa
Peterson, C. F. ..... Independence
Petzke, E. A. ..... Hixton
Peterman, M G. ..... Milwaukee
Pfefferkorn, E. B. ..... Oshkosh
Phelps, E. J. ..... Elderon
Pierce, D. F. ..... Hales Corners
Pitz, M. N. ..... Neenah
Pleyte, A. A. ..... Milwaukee
Pomainville, G. J. ..... Nekoosa
Post, C. C. ..... Barron
Powers, H. W. ..... Milwaukee
Prentice, J. W. ..... Amery
Prentiss, P. ..... South Wayne
Prill, H. F. ..... Augusta
Raasoch, H. ..... Nelsonville
Rath, R. R. ..... Granton
Rauch, W. A. ..... Valders
Reagles, R. ..... Arlington
Rector, A. E. ..... Appleton
Redelings, T. J. ..... Marinette
Reineck, C. ..... Appleton
Riley, E. A. ..... Park Falls
Ringo, H. F. ..... Montreal
Riordan, J. F. ..... Berlin
Rodecker, R. C. ..... Holcombe
Rogers, A. W. ..... Oconomowoc
Rosholt, J. A. ..... La Crosse
Rothman, L. ..... Wittenberg
Rowley, B. B. ..... Milwaukee
Reuthin, K. A. ..... Barron
Sattre, O. M. ..... Rice Lake
Schemmer, A. L. ..... Colby
Schmidt, Erwin ..... Madison
Schmidt, J. A. ..... Brillion
Schroeder, E. L. ..... Shawano
Schulberg, P. A. ..... Durand
Schwarz, S. G. ..... Marshfield
Seaman, G. E. ..... Milwaukee
Seeger, S. J. ..... Milwaukee
Seegers, F. W. ..... Milwaukee
Seemann, W. O. ..... Eau Claire
Seidel, J. G. ..... Warrens
Sheehy, T. J. ..... Tomah
Shepard, E. L. ..... Brandon
Simenstad, L. O. ..... Osceola
Sisk, I. R. ..... Madison
Sleyster, Rock ..... Wauwatosa
Smedal, Eilef ..... La Crosse
Smedal, E. A. ..... Viroqua
Smiles, C. J. ..... Ashland
Smith, J. F. ..... Wausau
Smith, S. M. B. ..... Wausau
Smith, Woodruff ..... Ladysmith
Snodgrass, T. J. ..... Janesville
Snyder, Karl ..... Portage
Somers, A. J. ..... Chippewa Falls
Southwick, F. A. ..... Stevens Point
Stack, G. F. ..... Independence
Stachle, Max ..... Manitowoc
Stang, H. M. ..... Eau Claire
Steves, B. J. ..... Menomonie
Stoddard, C. H. ..... Milwaukee
Stoland, I. ..... Eau Claire
Stovall, W. D. ..... Madison
Stranberg, W. L. ..... West Allis
Stubenvoll, C. E. ..... Shawano
Stuesser, C. N. ..... Ashippun
Stuessy, S. G. ..... Madison
Teschner, P. A. ..... Milwaukee
Thayer, F. A. ..... Beloit
Thompson, F. A. ..... Milwaukee
Tierney, E. F. ..... Portage
Tousignant, A. N. ..... North Milwaukee
Towne, W. H. ..... Shiocton
Trankle, H. M. ..... Bloomer
Tucker, W. J. ..... Ashland
Tupper, E. E. ..... Eau Claire
Turgasen, F. E. ..... Manitowoc
Tyvand, J. C. ..... Whitehall
Van Hecke, D. S. ..... Phillips
Venning, J. R. ..... Ft. Atkinson
Vogel, C. C. ..... Elroy
Vosburgh, W. H. ..... Denmark
Wagoner, F. F. ..... Clayton
Wakefield, G. F. ..... West Salem
Wallis, J. H. ..... Rice Lake
Warfield, L. M. ..... Milwaukee
Werner, Nels ..... Eau Claire
Werner, R. F. ..... Eau Claire
Whitehorn, E. E. ..... Vesper
Wilkinson, M. R. ..... Oconomowoc
Willett, T. ..... West Allis
Williams, A. E. ..... Boyceville
Windesheim, G. ..... Kenosha
Wink, R. H. ..... Granton
Witcpalek, W. W. ..... Algoma
Wolf, H. E. ..... La Crosse
Wright, J. C. ..... Antigo
Young, M. L. ..... Ashland
Ziegler, J. E. B. ..... Eau Claire

GUESTS

Abt, Isaac A. ..... Chicago
Alvarez, W. C. ..... Rochester
Bassoe, Peter ..... Chicago
Berglund, Hilding ..... Minneapolis
Braasch, William F. ..... Rochester
Campbell, A. P. ..... Ellsworth
Campbell, E. J. ..... Oshkosh
Clough, J. A. ..... Eau Claire
Crumbine, S. J. ..... New York City
Devine, E. T. ..... Washington
Dinsmore, R. S. ..... Cleveland
Flower, D. R. ..... Park Falls
Gaillardet, L. P. ..... Fairchild
Gray, R. J. ..... Brooklyn
Gunn, F. H. ..... Minneapolis
Harkness, Gordon F. ..... Davenport
Hayden, Edward M. ..... Eau Claire
Hirschboeck, E. ..... La Crosse
Lauder, C. E. ..... Viroqua
Leathers, W. S. ..... Nashville
Ludden, R. H. ..... La Crosse
Madison, B. ..... Sand Creek
Malone, J. Y. ..... Eau Claire
McCormick, S. A. ..... Almond
Mock, H. E. ..... Chicago
Moran, C. J. ..... La Crosse
Murphy, I. J. ..... Minneapolis
Murphy, William P. ..... Boston
Pollock, Lewis J. ..... Chicago
Ribenack, Geo. A. ..... Haugen
Sandin, N. V. ..... Maiden Rock
Schlomovitz, H. H. ..... Milwaukee
Schwyzer, Arnold ..... St. Paul
Skogen, T. T. ..... Hudson

Slayton, W. T. ..... Morrisville
Smith, Elsworth S. ..... St. Louis
Suker, George F. ..... Chicago
Tarrell, L. A. ..... Milwaukee
Thorsness, E. T. ..... Cumberland
Van Zandt, Frances ..... Madison
Wickham, Catherine ..... Eau Claire

COMMITTEES ANNOUNCED

The following committee appointments were submitted to the House of Delegates by President-Elect John J. McGovern and confirmed by the House. Under the new constitution, hereafter each incoming President will make one appointment for a three year term on each committee with the exception of the committees on the study of the nursing problem and licensure of hospitals which are special committees. Appointments announced follow:

1. The Committee on Scientific Work.
   3 years—Stanley Seeger, Milwaukee, Wis.
   2 years—A. W. Rogers, Oconomowoc, Wis.
   1 year —H. P. Greeley, Madison, Wis.
2. The Committee on Public Policy.
   3 years—O. B. Bock, Sheboygan, Wis.
   2 years—Dexter H. Witte, Milwaukee, Wis.
   1 year —D. L. Dawson, Rice Lake, Wis.
3. Editorial Board.
   3 years—Oscar Lotz, Milwaukee, Wis.
   2 years—J. F. Smith, Wausau, Wis.
   1 year —Hoyt Dearholt, Milwaukee, Wis.
4. The Committee on Medical Defense.
   3 years—A. J. Patek, Milwaukee, Wis.
   2 years—G. W. Nott, Racine, Wis.
   1 year —E. C. Carey, Reedsville, Wis.
5. The Committee on Medical Education and Hospitals.
   3 years—C. R. Bardeen, Madison, Wis.
   2 years—L. F. Jermain, Milwaukee, Wis.
   1 year —Joseph W. Lambert, Antigo, Wis.
6. The Committee on Medical Economics.
   3 years—J. F. Wilkinson, Oconomowoc, Wis.
   2 years—T. J. O'Leary, Superior, Wis.
   1 year —Ralph P. Sproule, Milwaukee, Wis
7. The Committee on Health and Public Instruction.
   3 years—W. D. Stovall, Madison, Wis.
   2 years—R. E. Mitchell, Eau Claire, Wis.
   1 year —H. C. Werner, Fond du Lac, Wis.
8. The Committee on Necrology.
   No appointments required.
9. The Committee on the Study of Nursing Problems.
   C. H. Stoddard, Milwaukee, Wis. Chairman.
   L. F. Jermain, Milwaukee, Wis.
   Karl Doege, Marshfield, Wis.
   Joseph Evans, Madison, Wis.
   R. C. Buerki, Madison, Wis.

Licensure of Hospitals.
   R. W. Blumenthal, Milwaukee, Wis. Chairman.
   C. A. Harper, Madison, Wis.

Surgeons to Meet at Madison

Madison has secured the 1927 meeting of the Wisconsin state branch of the American College of Surgeons.

This convention will bring to Madison the leading surgeons of the state of Wisconsin and surrounding states, together with the heads of all the hospitals in the state, and outstanding public health officials.

The dates selected are November 9 and 10, just preceding the Homecoming game, which arrangement makes it possible for those in attendance at this convention from distant points to remain over for this, the biggest game of the season, the Homecoming game.

All Fellows of the College in the state of Wisconsin and surrounding states will meet for two days of clinics, hospital conferences, and scientific meetings. A large community public health meeting will be held on the evening of November 10, at which time prominent surgeons from different parts of the United States will be present and address the meeting, to which the public is cordially invited.

This public meeting will give special consideration to interesting and instructive information concerning personal health and the proper use of the hospitals.

The American College of Surgeons, which has members in the United States, Canada, and South America, has been the outstanding organization of the country in the improving of hospital personal, hospital records, and hospital technic.

At this public meeting an opportunity will be given the public to ascertain just how a hospital should be used and when.

The headquarters for this convention will be at the Loraine hotel. Clinics will be held in the various hospitals of the city the mornings of November 9 and 10.

Dr. Corydon G. Dwight is chairman of the local committee on arrangements, and Dr. Albert Tormey is the secretary.

Both Dr. Franklin H .Martin, director general, and Dr. Bowman C. Crowell, associate director general, of the American College of Surgeons, were in Madison recently and approved of the facilities which were offered here. They spoke in high terms of the hospital facilities which are already available in Madison.

Organization of Boards of Health in Wisconsin and States Bordering on Wisconsin: Illinois, Indiana, Iowa, Michigan, Minnesota and Ohio

Compiled by Beatrice Hager, Wisconsin Legislative Reference Library—1927

State	Board, How Constituted	Duties and Powers of Members	Length of Term	Secretary: provision for, how chosen, membership on board, length of term, whether or not full time.
ILLINOIS Rev. stats. 1925, ch. 65a, sec. 1; ch. 24a.	Note: State board of health abolished, and powers transferred to dept. of public health except regulation of practice of medicine and embalming. Director at the head; assistant director of public health; supt. of lodging house inspection. Advisory and non-executive board of public health advisers composed of five persons serving without compensation. Both executive and non-executive officers appointed by governor with consent of senate.	1. Have general supervision over health of people. 2. Act in advisory capacity for sewer and public water supply construction. 3. Make sanitary investigations, including schools and charitable institutions. 4. Maintain chemical, bacteriological and biological laboratories. 5. Purchase and distribute free of charge to citizens, smallpox and other vaccines. 6. Gather and preserve information relating to morbidity and other health problems. 7. Make investigations with regard to diseases and epidemics. 8. Disseminate information on public health. 9. Promote local health agencies and organizations, and enlist cooperation. 10. Inspect hospitals and sanitariums maintained by state and local authorities. Advisory board to conduct independent investigations of entire field of public health, and make recommendations.	Two years from the third Monday in January of each odd-numbered year and until successor appointed and qualified.	
INDIANA Stats. 1926, v. 2, ch. 62 (sec. 8117 - 8156); sec. 2655; sec. 10577.	Five members, four appointed by board of appointment consisting of the governor, secretary of state, and auditor of state. Two members appointed biennially who shall hold their office for four years. Vacancy filled by board of appointment. Board of health thus constituted shall elect a secretary, who shall be a physician, the health officer of the state, and shall hold his office for four years, and shall be a member of the board of health, with special duties.	1. Collect and study vital statistics. 2. Have supervision over local boards. 3. Supervise system of registration of births, deaths, marriages and diseases. 4. Make annual report of governor with suggestions as to public health legislation. 5. Make sanitary inspections and surveys, studying infectious diseases, and impure water supplies. 6. Establish quarantine for preventing spread of disease, destroying private property if necessary. 7. Regulate and prescribe all sanitary features of public buildings. 8. Pass rules for enforcement of state health and registration laws. 9. Discharge local health officer for incompetence. 10. Regulate adulteration and impurity in drugs. 11. Control of state laboratory of hygiene.	Four years.	See also under Board, how constituted, column 1. Executive officers of the board, and shall devote entire time to duties of office.
IOWA Code, 1924, sec. 2181-2227.	Commissioner of public health appointed by governor with approval of two-thirds of senate. Must be a physician especially trained in public hygiene and sanitation. Must not be on any college instructional staff or hold any other lucrative position during term. Also a *board* of health consisting of commissioner of public health, members of executive council, and five health officers to be appointed by governor; not more than one health officer from each congressional district. No compensation except traveling expenses—must meet semi-annually; oftener if necessary.	Department of Health—Duties 1. General supervision over public health and sanitation, including campaigns for general instruction in these subjects, and disseminating printed material. 2. Conduct surveys and investigations into causes of disease and epidemics. 3. Inspect sanitary conditions in state institutions. 4. Inspect localities regarding sanitary conditions, on petition. 5. Inspect and direct installation of sewer and garbage disposal plants. 6. Establish code for installation of plumbing. 7. Exercise supervision over housing. 8. Establish stations for distribution of vaccines, free of charge. 9. Administer venereal disease law. 10. Sole jurisdiction over disposal and transportation of dead bodies. 11. Administer vital statistics law. 12. Enforce laws licensing professions affecting public health. 13. Establish within the department all divisions necessary to carry on work required of it. 14. Make and enforce rules necessary to carry out functions with which it is charged, and require local boards to enforce them. *Board* of Health—Duties 1. Act as advisory body to state department of health. 2. Consider and study entire field of public health and sanitation. 3. Advise the department relative to causes of disease and epidemics, sanitary conditions in state institutions, public water supplies and sewage plants, contagious diseases and housing. 4. Recommend to the department policies and practices for carrying out its functions. 5. Investigate work of department. 6. Make recommendations on public health to governor and legislature.	Four years, commencing on July 1 in year of appointment (Commissioner of public health). Five health officers are appointed for two years.	*Board* of health: Elect a president and secretary to serve for one year, members of the board.

(Continued on Page 544)

THE JOURNAL BOOK SHELF

Overcoming Tuberculosis. An almanac of recovery. By Gerald B. Webb, M. D., former President, National Tuberculosis Association; President, Colorado School of Tuberculosis, Colorado Springs; and Charles T. Ryder, M. D., Colorado School of Tuberculosis, Colorado Springs. Third edition revised. Price, $2.00. Paul B. Hoeber, New York, 1927.

City Health Administration. By Carl E. McCombs, M. D., National Institute of Public Administration and New York Bureau of Municipal Research. The Macmillan Company, New York, 1927.

The Tired Child. By Max Scham, M. D., and Grete Scham, Ph. D. Price, $2.00. J. B. Lippincott Company, Philadelphia.

Methods and Problems of Medical Education. Sixth series. Division of Medical Education, The Rockefeller Foundation, 61 Broadway, New York City, 1927.

How to Make the Periodic Health Examination. A manual of procedure. By Eugene Lyman Fisk, M. D., Medical Director, Life Extension Institute, and J. Ramser Crawford, M. D., Assistant Medical Director, Life Extension Institute. The Macmillan Company, New York, 1927.

Practical Lectures on the Specialties of Medicine and Surgery. Delivered under the auspices of The Medical Society of the County of Kings, Brooklyn, New York. Second series, 1924-1926. With 110 illustrations. Price, $7.00. Paul B. Hoeber, New York, 1927.

Lectures on Internal Medicine. Delivered in the United States in 1926. By Knud Faber, M. D., Prof. of Internal Medicine, University of Copenhagen, Denmark. With 43 figures and charts. Price, $3.00. Paul B. Hoeber, New York, 1927.

A Textbook of Clinical Neurology. By Israel S. Wechsler, M. D., Assistant Prof. of Clinical Neurology, Columbia University, New York; Attending Neurologist, The Montefiore Hospital, New York. Octavo volume of 725 pages with 127 illustrations. Cloth, $7.00. W. B. Saunders Company, Philadelphia and London.

Collected Papers of the Mayo Clinic and the Mayo Foundation, 1926, Rochester, Minnesota. Octavo of 1329 pages, with 386 illustrations. Cloth, $13.00 net. W. B. Saunders Company, Philadelphia and London, 1927.

Medical Clinics of North America. Vol. X, No. 6, Heart number, May, 1927. Octavo of 211 pages with 101 illustrations and complete index to Vol. X. Per clinic year, July, 1926, to May, 1927. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

Lippincott's Pocket Formulary. By George E. Rehberger, M. D., author of Lippincott's Quick Reference Book. This little pocket therapeutics has been prepared to provide the practitioner with a conveniently sized ready reference manual. Price, $3.50. J. B. Lippincott Company, Philadelphia.

The Human Body in Pictures. By Jacob Sarnoff, M. D., Associate Surgeon, United Israel-Zion Hospital, Brooklyn. A visual text of Anatomy, Physiology and Embryology. Price, $2.00. Physician & Surgeons Book Co., Brooklyn, N. Y.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared original articles. By leading members of the medical profession throughout the world. Vol. II, 37th series, 1927. J. B. Lippincott Company, Philadelphia and London.

Diseases of the Skin. A practical treatise for the use of students and practitioners. By Oliver S. Ormsby, M. D., Clinical Professor and Chairman of the Department of Dermatology, Rush Medical College of the University of Chicago. Third edition, thoroughly revised. Illustrated with 521 engravings and 3 colored plates. Price, $11.00. Lea & Febiger, Philadelphia, 1927.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 153 E. Wells Street, Milwaukee, Wisconsin. These new books will be loaned for an inspection period only.

Manual of the Diseases of the Eye. For students and general practitioners. By Charles H. May, M. D., Director and Visiting Surgeon, Eye Service, Belleview Hospital, New York, 1916 to 1926; Instructor in Ophthalmology, College of Physicians and Surgeons, Columbia University, New York. Twelfth edition, revised, with 374 original illustrations, including 23 plates, with 73 colored figures. Price, $4.00. William Wood & Company, New York, 1927.

The usefulness of May's manual is again attested by the appearance of a new, the 12th Edition. Written for students and general practitioners, the common diseases have been more fully described and essential points emphasized, e. g.: differential diagnosis of conjunctivitis, iritis and glaucoma, ocular manifestations of general diseases, etc., while rare affections are only briefly mentioned.

In accordance with the progress of ophthalmology, the work has been fully revised, without, however, increasing its size, and also, the specialist will read with pleasure the concise presentation of important topics. Paper, print, and the many illustrations and colored plates are very good.—C. Z.

Nineteenth Report of The Henry Phipps Institute, University of Pennsylvania. For the study, treatment and prevention of tuberculosis. Henry Phipps Institute, Seventh and Lombard Sts., Philadelphia, 1927.

This report offers to the student of the study, treatment and prevention of tuberculosis a number of valuable articles. Included in these is a most thorough and comprehensive investigation of THE CONTAGION OF TUBERCULOSIS by Eugene L. Opie, Director of the Pathological Department and F. Maurice McPhedran, Associate in Clinical Research. After some ten years' study of nineteen families, embracing contact and non-contact children in different age groups, as well as a study of marital tuberculosis in thirty-four families, the following conclusions are given:

1. When latent tuberculosis is taken into consideration, tuberculosis exhibits the characters of a contagious disease and effects all children of households within which some member, suffering with tuberculosis, scatters tubercle bacilli.

2. Recognition of latent apical tuberculosis has demonstrated that tuberculous infection is transmitted to adults and adolescent children, and has shown that ap-

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proximately one-half of the partners of husbands and wives with open tuberculosis are infected after marriage.

3. Duration of exposure to open tuberculosis is an important factor in determining the character and severity of the resulting infection; in instances of recognizable tuberculosis of tracheobronchial lymph nodes the average duration of contact with tuberculosis has been approximately four and a half years, and in instances of latent apical tuberculosis nearly twice as much.

4. Dispensaries for the care and control of tuberculosis should be organized so that spread of latent infection within the family may be recognized and prevented. A chart for each family, depicting the severity of latent and manifest disease disclosed by quantitative tuberculin reactions and roentgenological examination, will forcibly direct attention to effective means of control.

5. Latent tuberculosis often becomes manifest. Certain forms of latent infection foretell the approach of clinically recognizable disease. These are (1) infection recognizable by tuberculin reaction during the first two years of life, (2) tracheobronchial tuberculosis in children recognized by roentgenological examination, and (3) latent apical tuberculosis in adolescent children. Children with these forms of tuberculous infection should be examined at frequent intervals, and treated as though they had recently arrested tuberculosis.

6. All adults in whom latent apical tuberculosis has been recognized should receive the same care as patients with arrested phthisis.—B. E. H.

A Text Book on Pathology. By Alfred Stengel, M. D., Professor of Medicine, University of Pennsylvania, and Herbert Fox, M. D., Professor of Comparative Pathology, and Director of the Pepper Laboratory of Clinical Medicine, University of Pennsylvania. Eighth edition, reset. Octavo of 1138 pages with 552 text illustrations, many in colors, and 18 colored plates. Cloth, $10.00 net. W. B. Saunders Company, Philadelphia and London, 1927.

This book has for a long time been one of the standard American works on Pathology. The eighth revision gives testimony to this fact. The subject is extensively and thoroughly covered and the book has been kept comparatively small.

The arrangement of the subject matter is as good if not better than is found in any similar work on Pathology. For this reason, it is ideal for teaching purposes and the proper sequence of subjects makes it an interesting and easily readable book for general use.

The illustrations, both gross and microscopical, are sufficient, well selected and very clearly printed. There are a number of colored plates which are as good as the average. True color representations are, however, practically never a success.

The chapters on the eye, ear and skin which are not found in many works on Pathology add to the book's completeness.

The references are not numerous, but well chosen.

The book is recommended as a standard work on Pathology.—E. L. T.

Heart and Athletics. Clinical researches upon the influence of athletics upon the heart. By Dr. Felix Deutsch, Privatdocent in Internal Medicine at the University of Vienna, and Dr. Emil Kauf, Assistant at the "Heart Station" in Vienna. English translation by Louis M. Warfield, M. D., former Professor of Internal Medicine, University of Michigan. Price, $2.50. C. V. Mosby Company, St. Louis, 1927.

A most interesting and instructive collection of statistics revealing the influence of various types of athletic endeavor upon the size of the cardiac outline.

Various sections give the reader a good resume of the earlier observations made in the field. They are followed by other sections which incorporate the author's own observations on exercise for pleasure, and competitive athletics. Among the latter are swimming, light athletics, soccer football, rowing, wrestling, mountain climbing, skiing, boxing, bicycle riding, fencing, hockey, hand ball, tennis, etc.

This data is based upon more than one thousand examinations of repeatedly controlled athletes. Orthodiagrams, and in doubtful cases teleroent genograms, were continuously used.

There is no other single volume in English which can give an authoritative opinion upon the influence of athletics upon the heart.

The translation is well done.—M. R.

Textbook on Diseases of the Skin and Syphilis. Designed for the Use of Students and Practitioners. Albert Strickler, M. D., Professor of Dermatology and Syphilology, Temple University, Department of Medicine. Cloth. Price, $8.00, pp. 689, with 218 illustrations. Philadelphia, F. A. Davis Company, 1927.

This volume appears as the most recent addition to the list of textbooks on the subject indicated, a list fairly replete with adequate and, in many instances, excellent expositions on the clinical aspects of skin diseases and syphilis. Dr. Strickler's book is characterized by brevity, and the various diseases, grouped on the basis of etiology or pathologic similarity in most instances, are considered under the captions of definition; eruption, with the subcaptions of description, progress, distribution, subjective and constitutional symptoms; etiology; diagnosis, prognosis, and treatment. In many instances his classification is at variance with the accepted texts without adequate explanation for the deviation, this deviation being in some cases inconsistent with the state of our present knowledge of the subject. The illustrations are very dissimilar in quality, both in subject matter and in technic of preparation. Some of them are such as to definitely lower the standard of the text. In differential diagnosis, the tabular form is employed, making for ease of reading but necessitating curtailment of the discussion of differential points which are of importance to the novice.—L. M. W.

DIETITIANS MEET

The Tenth Annual Convention of the American Dietetic Association is to be held in St. Louis, Missouri, October 17-18-19, 1927. The headquarters of the convention will be at the Hotel Statler, which is in the heart of the city from which transportation to all points of interest is most easy.

The association was founded in 1918 by pioneers in administrative hospital dietetics and from its small beginning the association has grown into a national organization of highly trained workers in nutrition and allied fields.

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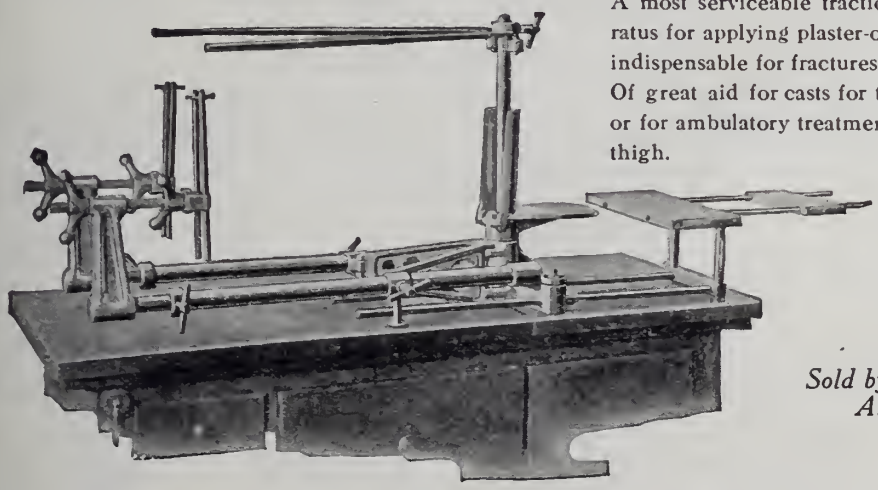

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The program of the American Dietetic Association at its Annual Meeting covers all of these fields. Speakers are provided from among the laity and the medical profession who discuss authoritatively the problems of each group. The latest work in nutritional research is brought to the Association. In addition to this, valuable information which no dietitian interested in her future and the future of her profession will want to miss.

Organization of Boards of Health in Wisconsin and States Bordering on Wisconsin: Illinois, Indiana, Iowa, Michigan, Minnesota and Ohio

Compiled by Beatrice Hager, Wisconsin Legislative Reference Library—1927

(Continued from Page 539)

State	Board, How Constituted	Duties and Powers of Members	Length of Term	Secretary: provision for, how chosen, membership on board, length of term, whether or not full time.
MICHIGAN Compiled laws, 1922, sec. 5000 (1) to sec. 5036; 5145; 5180 (11) 5180 (9); 6906-6915; 8396 (6); 2331 (35); 2331 (41); 10857 (1).	State board of health abolished, powers and functions transferred to: State health commissioner appointed by governor with consent of senate. Must be a registered physician with at least five years experience or degree of doctor. Must devote entire time to office. State health commissioner appoints a deputy. State Council of Health: Five persons appointed, with consent of senate, by the governor.	Duties and powers of state health commissioner: 1. With concurrence of at least three members, of state council of health, to make rules and regulations to protect public health in regard to diseases and contamination. 2. When conditions in any city become a menace, health commissioner may take charge of health laws, rules, etc., but not in city with full time health officer, without consent of state council of health. 3. Prohibit public meetings in case of epidemics, with consent of state council of health. 4. Employ a bacteriologist and prescribe his work. 5. Have control over waterworks and sewage disposal systems. 6. Furnish and distribute antitoxin and other products for prevention and treatment of diphtheria. 7. Make rules and regulations in regard to venereal diseases and provide for treatment at state sanitariums. 8. Approve specifications for sanitation, light and ventilation in convents, asylums, hospitals, jails and sanitariums and prepare an approved list of sanitariums. 9. License embalmers and regulate practice of embalming. 10. Administer and enforce act providing for first aid on trains. 11. Enforce housing laws. Duties and powers of state council of health; purely advisory; see under duties and powers of state health commissioner, above.	Term of health commissioner is four years. Terms of members of state council of health: Original appointments made for two, four and six years; thereafter each vacancy to be filled for six years when it occurs.	
MINNESOTA Gen. stats. 1923, sec. 5336-5394; 5817-5822.	Board of nine members, learned in sanitary science, appointed by governor.	1. Exercise general supervision over all health officers and boards. 2. Investigate sanitary conditions, and causes and sources of epidemics and diseases. 3. Gather and diffuse general public health information. 4. Advise all boards in sanitary features of construction of public buildings. 5. Provide special instruction in care of expectant mothers and infants, cooperating with other agencies. 6. May control by any means the following matters: Use of tainted vegetable or animal matter in manufacturing; disposal of sewage; disposal and transportation of the dead, including licensing of embalmers; maternity hospitals; water pollution; public institutions and hotels; communicable diseases, including venereal diseases; infant blindness; furnishing of vaccine matter; filth of any kind injurious to the public health; collecting and recording of vital statistics; sanitary conditions of lumber and other industrial camps; sanitary conditions of tourist camps.	Appointed for such periods that the terms of three members will end on the first Monday in January of each year.	Elected by the board; may or may not be a member of the board; to serve during pleasure of the board. Executive officer, and must see that functions laid upon board are performed. Only person on board who receives a salary ($2,500 per year); other members reimbursed for expenses in attending meetings only.
OHIO General Code 1926, ch. 19 (sec. 1232-1261 43).	Organized as a department of health, to take the place of a board of health, abolished 1917. Department of health to consist of commissioner of public health and public health council. Public health council to consist of commissioner of health, and four appointive members to be appointed by the governor. At least two ap-	Commissioner of health performs executive duties: 1. Takes over work of secretary of board of health. 2. Administer laws relating to health and sanitation and regulations of the department of public health. 3. Prepare sanitary regulations to submit to the public health council. 4. Call special meetings of council of health. 5. Takes over all duties previously performed by board of health:	Four years, so appointed that one term shall expire each year.	Commissioner of public health shall, upon request of the public health council, detail an officer or employee of the public health department to act as secretary of the council.

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TONSILLECTOMY may not always present the most suitable manner of treating tonsillar infections and hypertrophied tonsils. It implies the usual risks of surgery to which some patients cannot be subjected. ¶ Quartz light therapy has been reported not only as a factor in causing the shrinkage of tonsils, but also as a means for promoting reconstructive metabolism . . . in many cases regenerating the locality and obviating the necessity of more drastic measures. ¶ The bactericidal quality of quartz light accounts for its broad use in general infection of the upper respiratory tract.

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State	Board, How Constituted	Duties and Powers of Members	Length of Term	Secretary: provision for, bow chosen, membership on board, lengtb of term, wbether or not full time.
	pointive members must be pbysicians witb training or experience in sanitary science. Note: Commissioner of bealtb is listed as an appointive officer, but section creating his office makes no provision for manner of appointment. Governor designates cbairman of public healtb council for eacb year. Members of council receive traveling and other expenses only.	(a) Publish and distribute public bealtb manual. (b) Define and regulate hospitals and dispensaries. (c) Distribute antitoxins. (d) Approve local water supply and sewage systems, and sanitary conditions of public buildings. (e) Superintend waste disposal of factories, etc. (f) Investigate stream pollution. (g) May establish and maintain a cbemical and bacteriological laboratory. (h) Prescribe special rules for and disseminate information on maternity and infant hygiene. Duties of council of healtb: 1. Make and amend tbe sanitary code, to apply througbout tbe state. 2. Take evidence in appeals from decisions of commissioner of bealth. 3. Conduct hearings in cases arising out of its supervision of sanitary regulations. 4. Consider and advise tbe commissioner on any matter relating to preservation or improvement of tbe public healtb. 5. Not to have or exercise any executive or administrative functions.		
WISCONSIN Statutes, 1925, cb. 140.	Board of seven members appointed by the governor witb tbe consent of the senate. One member cbosen president. Term fixed by the board, and duties prescribed by by-law or statutes. Members otber tban tbe secretary receive compensation of ten dollars per day when engaged in performance of official duties, but not to exceed two hundred dollars to eacb in any one year. Meets in January and July of eacb year, and at otber times as directed by tbe board or its president.	1. Exercise general supervision over healtb of citizens and compile and study vital statistics of tbe state. 2. Study causes of disease, especially epidemics, and causes of mortality. 3. Make sanitary inspections and surveys in all parts of tbe state. 4. Inspect private property. 5. Execute wbat is necessary for prevention and suppression of disease. 6. Advise public officers on beating and ventilation of public buildings. 7. Establisb bureaus and have all power to bring action into court for enforcement of laws and rules. 8. Disseminate bealth information, cooperating witb secondary scbools and colleges, including Wisconsin university. 9. Make and enforce rules and orders governing duties of all healtb officers and bealtb boards. 10. May appoint a state sanitary inspector, who shall be a medical practitioner bolding a Wisconsin license. 11. Divide tbe state into five sanitary districts, and appoint for eacb a deputy state officer, who shall instruct and assist local bealth boards and officers, and enlist cooperation of physicians. 12. Call conference of local bealtb boards and officers.	Seven years. One member appointed each year beginning on first Monday in February in year of appointment.	Elected by the board. May or may not be a member, but becomes a member during bis term of office. Is the executive officer of the board and the state healtb officer. Compensation fixed by tbe board.

THERAPEUTIC NOTES

New and Nonofficial Remedies

In addition to the articles enumerated previously the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories

Acetarsone.

Amiodoxyl Benzoate—Abbott.

Ephedrine Sulphate—Abbott.

H. K. Mulford Co.

Diphtheria Toxin-Antitoxin Mixture, New Formula, Park-Banzhaf's 0.1 L+.

Erysipelas Streptococcus Antitoxin (Concentrated)—Mulford.

Nonproprietary Articles

Amiodoxyl Benzoate.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

Diphtheria Toxin-Antitoxin Mixture, New Formula, Park-Banzhaf's 0.1 L+ (New and Nonofficial Remedies, 1927, p. 241)—This product is also marketed in packages of one 10 cc. vial, representing three immunizing treatments. H. K. Mulford Co., Philadelphia. (Jour. A. M. A., August 20, 1927, p. 600.)

PROPAGANDA FOR REFORM

Ethylene—II.—The A. M. A. Chemical Laboratory reports another examination of the quality of ethylene for anesthesia which is on the market. The Laboratory reports on the composition of "Ethylene for Anesthesia" of the Certified Laboratory Products (which has been accepted for New and Nonofficial Remedies) and a specimen of the ethylene of the Kansas City Oxygen Gas Company, the quality of which had been questioned in a hospital. The Laboratory found both products to meet the requirements of New and Nonofficial Remedies. The Laboratory repeats its previous recommendation, that physicians use only the brands of ethylene described in New and Nonofficial Remedies. (Jour. A. M. A., August 6, 1927, p. 451.)

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Cancer; The Problem of Its Treatment*

By KARL W. DOEGE, M. D.
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At the outset it may be well to recall to our minds certain now generally accepted facts or convictions concerning cancer. These we will have to keep constantly before us when we discuss the practical method of treating this disease in its various types, its different stages, and its manifold locations.

In the first place we do not as yet know what cancer really is. We know its effect, but its pathogenesis, whether it is microbic in origin or a purely cellular dystrophy, is as yet not determined.

2. We are forced to look upon cancer as a constitutional disease, which constitution is hereditary.

3. The clinical diagnosis of cancer of the inner organs is lamentably uncertain even with the most modern methods of serum, blood and x-ray examinations. Statistics show us that we fail to recognize cancer clinically in from 12 to 33% of all cases.

4. The microscopic diagnosis of cancer does not rest upon an absolutely secure basis; at least, the interpretation of sections by various equally competent pathologists may vary widely as to whether malignancy is present or not.

5. Cancer is a disease of advanced age. The older we get the more of us will acquire cancer and, if the other diseases following in the wake of senility will but spare us, we may eventually reach the point where we all will die of cancer.

6. Cancer cells may lie dormant in our tissues for many years.

7. A five year freedom from malignant manifestations after the removal of a cancer is no guarantee against its recurrence ten or twenty years later.

8. In the ideal sense of the word a cancer is never cured. This blunt statement, if not modified, should discourage us from the very start in our effort to cure it did we not know, that to a certain extent, such is the case with a good many affections. It will not be so disheartening if we recall that a tuberculosis is never cured, neither is an endocarditis or myocarditis, nor gastric ulcer nor a toothache for all that; if by a cure we mean the ideal demand of all therapy, i. e., a *restitutio ad integrum.* A man may live comfortably, though somewhat handicapped, with a latent tubercular focus, with incompetent heart valves, with gastric ulcer scars or focal dental infections; as, also, with malignant, though dormant, cancer cells or metastoses in his lymph glands, bone, lungs or liver. After the healing of the primary focus in pulmonary tuberculosis, the disease may be held in abeyance for many years or even permanently so, though we fully know that tubercle bacilli still abount in his lymph glands and other tissues. That such, also, is the case in cancer, every surgeon, looking back upon a practice of many years, can verify from his own personal experience. About fifteen years ago I operated upon a far advanced cancer of the lip. Three fourths of the lower lip had to be removed and complete bilateral block dissection of his neck was done. He came back two times within two years for the removal of metastatic cancerous glands in the lower part of the neck and then lived eight years longer, returning finally with metasases in his liver of which he died. While we must admit that the first radical operation did not *cure* the patient, yet we could speak with a certain degree of justification of a cure, which in this case lasted ten years.

Cancer, as said before, is a constitutional disease. In favorable instances we can remove the visible evidence of the disease, but the predisposition to cancer remains. This predisposition to cancer it is impossible, as far as we know now, to change. A specific remedy against cancer does not exist, and in the light of our present understanding of cancer can *never* be found, even though

*The second of a series of addresses by members of the clinical preceptorial staff of the University of Wisconsin Medical School, University of Wisconsin Medical Society, February 17, 1927.

Congress should vote, as has been proposed, $5,000,000 to the man who finds a cure for it; neither is there a specific remedy against tuberculosis. Among the innumerable methods for the treatment of cancer but two are deserving of closer study. These have survived the trial of actual experience and of clinical tests. I mean radical surgical excision and the use of the x-ray. All other methods, however brilliantly they have been in the limelight for a while, have not stood the test of time and that of clinical experience. Before discussing surgical excision and x-ray more fully, it may be of interest to review some of the methods that have fallen by the wayside. It will not only widen our knowledge of cancer if we briefly review them, but we may, also, learn what it was that inspired so much confidence and gave so much hope to their erstwhile, no doubt, earnest and enthusiastic advocates; perhaps even now there is still a kernel of wheat in all this chaff.

The use of the Coley serum, consisting of streptococcus and prodigiosus toxins is well known to all Americans. Occasional good results have been and are still obtained. It has done some good in sarcomas but has no effect on cancer, and its use for the disease under discussion is now a thing of the past.

I shall pass over the period of active and passive immunization against cancer. These were efforts to built up tissue resistance. In spite of the colossal work expended on it and, in spite of apparent initial successes, this epoch may be regarded as ended and concluded without result.

AUTOSEROTHERAPY

Then came the period of autoserotherapy. Lewin in 1918 observed a case of cancer of the breast with extensive abdominal metastases and ascites. An injection under the skin of from ten to twenty cc. of the ascitic fluid was followed by a marked improvement. The almost moribund patient improved and finally recovered to such an extent as to still be in the best of health after a period of two and one-half years. As the results of this autoseroptherapy could not be duplicated by others to a pronounced degree an improvement of the method was thought possible if an extract of the tumor itself were used; but Blumenthal early drew attention to the possibility and danger of injecting living cancer cells with the tumor extract into the tissues of the patient. He then devised a plan of destroying the living cancer cells of the tumor extract by previous autolysis and the era of autolysintherapy began. The tumor substance was finely divided and for three days was put in physiologic salt solution. Then it was put for an hour in an incubator, filtered and then heated to 56 degrees C. Twenty or thirty cc. injected into the veins in Lunkenhein's hand produced marvelous results that began at once. Keysser, also used it, but in smaller doses. He had no decided results in full grown tumors or metastases but observed remarkable effects in the prevention of recurrences. It even this were but a uniform result it would constitute a distinct advance in cancer therapy. It would not matter how we would explain its action, whether we would call it a ferment or a vaccine. After all these methods had been tried out, thoroughly discussed and compared, it finally appeared most likely that we were dealing with a reaction, similar to that attained by proteintherapy. The parenteral injection of albumin markedly acts upon the nervous system, the hemapoietic system and upon the endocrine secretions. This it probably does through protoplasmic activation, "stepping up" so to say, the general defense measures of the tissues whatever they may be. Whatever the explanation of their results may eventually be, it seems that a certain something has been uncovered which may prove to be a nucleus of useful application in the treatment of cancer especially in the management of the postoperative period. One realizes, of course, that much of this is fantastic and imaginative, but apparently *something* has resulted from the tremendous amount of work done along this line.

CHEMICAL THERAPY

We must not forget to mention the efforts that have been made with chemical therapy. The use and often the benefit of arsenic in nonoperable cases of cancer is old and well recognized. The fact that the blood of cancer patients has 10% less of calcium than the normal individual has prompted many to supply the deficiency by calcium medication, especially as it was found that calcium also increased the assimilability of arsenic by the cell. Potassium iodide has been followed by decided improvement, but whether in such cases we deal with late syphilitic or with arteric-sclerotic lesions may well be pondered over. In this connection we may also consider the preparation of gold, lead and other metals that have so recently been advocated. Chemical substances alone or

combined with electricity or magnetism have been used with benefit here and there by earnest physicians. These, as well as autoserotherapy, are also the methods so extensively exploited and commercialized by rather well informed charlatans, men of a rather higher type than the ordinary quack or cancer specialist. Of all the methods of treatment it can be said that occasionally brilliant results have been obtained once by this and again by that method, but whenever any of these methods was applied as a routine measure in the treatment of carcinomata general failure has been the rule.

SURGERY

As yet most success has been attained by operative measure: to this the most competent of men agree. I cannot, of course, go into the details of surgical treatment except to state that recently there seems to be a tendency to recede from the once prevalent dictum to make the widest possible excision, one that included the nearest lymph glands in one block. While the majority of surgeons still strictly adhere to this dictum, there are others who after careful statistical research feel that such extensive mutilation is not always necessary and that a simple excision of the breast in case of carcinoma of the mamma, for instance, without invading the axilla is sufficient. The question is still in a state of flux. The inevitable, though often slight risk, that goes with every surgical operation; the very evident danger of disseminating cancer cells at the time of the operation, together with the generally low percentage of long lasting cures through operation, has served to keep uppermost in the minds of physicians as well as of the public a wish and a hope for a less dangerous, perhaps non-operative method in the treatment of cancer, one that is at least of equal value with the operative procedures.

In view of what I shall say later, and in order not to be misunderstood, I wish to state right here that we do *not now possess* such a method equal in value with the surgical operation. This should be emphasized, on account of the many publications of cases treated with so-called conservative methods, lest the impression may gain ground that next to operation we possess means that permit us to choose at pleasure between operative and non-operative treatment and expect equally good results. This is *emphatically not* the case, generally speaking. There are certain carcinomata where we may well raise the question, "Is it best to operate or shall we select a non-operative procedure, such as radiation?" But in the *overwhelming* number of cases we have no choice but the use of the knife.

RADIOTHERAPY

Now let us turn to radiotherapy. It may be well to say at the outset that the treatment of cancer by radiotherapy has by far *not achieved* what was expected of it. The hope that radiotherapy might be called upon to replace the knife must, as yet, be definitely set aside. The question can be answered differently when we consider whether or not radiotherapy also represents a valuable factor in the treatment of malignant disease. To this we can, *without hesitation,* reply in the affirmative. It may even be said positively that for certain forms of carcinoma and in certain location radiation is in close competition with operation and in selected cases it is even *preferable* to it.

In what way does radiation act upon cancer? It is now definitely conceded that an exposure to x-ray or radium that does not kill normal tissue cells does not kill cancer cells either. In fact it has very little effect upon it. A radiated cancer cell when transplanted into normal tissue will grow just the same, i. e., it is not killed or even seriously injured by radiation. On the other hand, a non-radiated cancer cell that has been transplanted into previously radiated tissue will not grow. It would seem that the x-ray changes the soil in such a way that the cancer cannot multiply. It possibly does this by stimulating the defense measures of the system to greater activity. We conceive that the tissues react to the invading cancer cells as they do to foreign bodies, i. e., it surrounds it with fibrous tissue cutting off nourishment, producing a dead or a dormant cell. That fibrous tissue forms a hindrance to cancer growth seems probable. It preponderates in the least malignant forms of cancer, like the scirrhus, and is almost absent in the very malignant forms of adenocarcinoma.

We have spoken several times of the defense measures of the system; these, of course, are quite hypothetical. What the nature of this defense measure or healing factor is, we do not know. It is a conception borrowed probably from observations on infectious diseases. It is quite thinkable that this hypothetical healing factor would be able to hinder the further development of a just beginning carcinoma if it could be produced in larger quantities. But what is a beginning carcinoma? Is it the primary cancer cell of Virchow from which others

form, or is it that cell in which the albumins are not as yet increased to the detriment of the globulines, but are biologically tending that way, a cell gradually becoming what we call carcinomatous? The first would be the fully developed carcinoma, the other would be the precancerous stage, biologically and histologically speaking. Increased protoplasmic activation brought about through protein therapy, through arsenic, potassium iodide, through autolysine, autoserotherapy, and irradiation, might easily prevent the further development of the pre-cancerous cell into a full grown carcinoma. However, in the treatment of cancers as we meet them, we are dealing with fully formed malignant cells, the further growth of which we wish to hinder by some process.

In actual practice it is likely that the surgeon will decide to remove a clinically recognized cancerous growth in bulk by operation if this is still possible. If the case is considered not operable he will resort to the use of the actual cautery or diathermy, or if even these are contraindicated he will resort to radiation, either by x-ray or radium. The question as to the use of radiation in regard to doses, frequency, whether before or after operation, is still in a state of most violent flux. It seems, however, pretty well conceded that epitheliomas of the skin are well treated by radiation, so that surgical measures are but rarely necessary. Nothing as yet is settled as to the use and benefit to be derived from preoperative and postoperative radiation.

MEDICAL SUPERVISION

I would not feel that I had said much of any importance this evening if I would not stress a point that is so self-evident, but which in the great bulk of cases is entirely everlooked. I refer to the great importance of long continued medical supervision and care of the patient after the removal of the primary growth. If there is any truth at all in the supposition that dormant cancer cells and metastasis can be held in abeyance for many years by stimulating the defense mechanism of the system, then it becomes the duty of the surgeon to re-examine his patients at regular set intervals, year after year, as long as the patients live. To remove recurrences at once, to radiate deep metastases when these become evident, to keep him in the prime of health by advice or medication if need be, is as much of a duty of the attending surgeon as was the primary removal of the growth. If, in conclusion, I were to formulate the conception as held in the Marshfield Clinic to control cancer generally, and in the individual patient, I would for practical purposes recognize five periods or states where our advise or therapeutic effort would be of avail.

1. The constitutional state, which is hereditary.
2. The biologically precancerous state which is acquired and systemic.
3. The histologically precancerous state which is acquired and local.
4. The state of the actually formed cancerous growth, which is local but a short time, and then becomes general.
5. The post-operative state or period.

The therapeutic thought that should guide us in each of these five periods I would formulate thus:

The hereditary tendency we combat by advising against the marriage of such participants where there is an outstanding familiar history of cancer. The biologic precancerous stage, where the normal cell shows a tendency to deteriorate and possibly become a cancer cell, we cannot as yet detect clinically, but practically it is probably influenced by fostering good vigorous health at all times and by periodic health examinations. This stage is purely hypothetical. The third or histologically precancerous stage we combat by the removal of all benign growths, such as warts, scars, etc., which by virtue of their position on the body are subject to frequent irritation, by guarding against persistent irritation or slight traumatisms to the skin or mucous membranes anywhere, and by watching the effect of traumas to bone and other organs where cancers are liable to occur. (Lip cankers, sharp teeth, hot foot, etc.)

The state of actual malignant growth we treat by surgery or irradiation. The fifth and post-operative stage is a perpetual care for ever after. It requires the closest scrutiny as long as the patient lives. The patient should be examined every three months locally and generally, and he should be so informed when the treatment of the case is first accepted. He should be carefully looked over for recurrences and metastases and when present these should be removed at once if possible. Routine blood examinations should be made and the body weight kept track of. Any slight anemia or loss of weight, not otherwise accounted for, should be considered suspicious of another cancerous outbreak and may be corrected by blood transfusions, by protein therapy, chemo-

therapy, and general stimulating doses of x-ray, singly or combined. A card handed to the patient when he leaves your care, describing briefly the tendency of cancer to recur, and the necessity of constant periodic observation will make him more intelligent and appreciative of your effort and more willing to cooperate with you. I have carefully avoided all description of technical detail of operation or other measures, dwelling upon principles rather than technique.

Urinary Tract; Accident Surgery*

By JAMES C. SARGENT, M. D.
Professor of Genito-Urinary Surgery, Marquette University, Milwaukee

While beginning to prepare myself on the above subject, it promptly occurred to me that I had hooked a much larger fish than I had either time or tackle to land. It is obvious that a consideration of accident surgery of the urinary tract, to be accomplished in a few brief minutes, must necessarily be quite restricted in its scope. I purpose only a general consideration of the broad surgical principles involved in the management of urinary tract injuries.

The urological literature is not profuse in this particular regard and such treatment as the subject receives in the urological text books and monographs shows clearly the marks of opinions of those of an earlier time. For example, I find in one of our most modern treatises on urology a remark to the effect that one of the outstanding reasons that women suffer rupture of the kidney but very infrequently is the protection offered by their corsets. I am sure you will agree that that refers to a time past. Seriously, though, the whole field of accident surgery has steadily undergone a remarkable change in recent years. What with the automobile, the age of industrial employment of women etc., it is little wonder that we grow bored at a recital of the causes of rupture of the bladder which prominently includes such things as piercing with a sword, goring with the horn of a bull and even overdistention from alcoholism.

It is not surprising that there is a paucity of literature dealing with accidental injuries to the urinary tract. To begin with, they are comparatively rare and occur infrequently in the usual practice of the urologist unless he happens to be connected with some hospital service handling a large list of accident cases. Evans and Fowler report that out of nearly eleven thousand surgical cases at Bethany Hospital only three were admitted for bladder injury. In reviewing material for this paper I find that fully nine out of ten accident cases which I have handled were on the service at Johnston Emergency Hospital and that only on the rarest occasion does a case of this type come along with the usual private surgical work.

Though there is a wide difference in the clinical and pathological pictures between injuries of the kidneys, the bladder, and the urethra, the various injuries to these structures have certain things in common. Regardless of the part of the urinary tract involved hemorrhage of some degree is certain to occur. Regardless of the location of the lesion, the question of urinary extravasation must necessarily be considered.

Hematuria, that is, bleeding into the urinary canal, is the one prominent and ever present indication of injury to the urinary tract. The mere fact that blood is being passed by the subject immediately insists that some injury has occurred to some part of the urinary apparatus. It means nothing more, however, until its type and general characteristics have been considered, when there develops a veritable mine of information regarding the location and extent of the particular injury responsible for it. When carefully analyzed, the symptom of hematuria alone will usually localize the structure that has been injured.

When pure blood is found oozing from the urethra, there can be no question but that the urethra has been injured. It must be pure blood, however, because an oozing of bloody urine from the urethra suggests an overflow incontinence occurring in a bladder over-distended with bloody urine. With the urethra injured it is usually impossible to pass a soft rubber catheter to the bladder and if it happens the catheter is permitted passage, clear urine is drawn from the bladder. In either case the injury is located in the urethra beyond peradventure.

So called "bloody anuria," when met with, is almost pathognomanic of rupture of the bladder. With the bladder frankly ruptured, a clonic spasm ensues and urine is forced through the rupture out of the bladder. The tenesmus prompts frequent

*Read before the Organization Meeting, Wisconsin Urological Society, Madison.

attempts at voiding, always with the same result, nothing more than the passage of a few drops of pure blood,—never any urine. Though such a symptom hardly needs further analysis, a catheter passed to such a bladder finds it empty. Even more pathognomanic, a few ounces of sterile water injected through the catheter never returns. With such findings, frank rupture of the bladder is certain.

If gross total hematuria (that is the voiding of urine found equally bloody in both glasses) does not actually localize the injury above the bladder, it at least denies either injury to the urethra or frank rupture of the bladder. True it is that it may occur in contusion of the bladder wall without frank rupture, but the presumption is always in favor of renal injury. This is especially true when pencil clots are passed accompanied by typical ureteral colic. When such occurs, the bleeding is not only localized to *a* kidney but to *the* kidney injured. Hematuria from renal injury and that from bladder contusion may be differentiated further by irrigation of the bladder through a soft catheter. When the bleeding is renal, the bladder is washed clear in one or at the most, two washings; when the bleeding is vesical, even numerous washings bring back some blood.

Extravasation of urine does not always accompany injury to the urinary tract. When there has been a frank rupture of either the kidney, bladder or urethra, however, it usually follows. When extravasation of urine occurs it is at once a benefit and a harm. A benefit in that it permits more accurate location of the lesion; a harm in that it seriously complicates the injury. In frank rupture of the lower urinary tract i. e., the bladder and urethra, extravasation of urine is always more or less continuous and if time elapses, quite extensive and destructive. The situation is not the same with the kidney. Even in extensive rupture of the renal parenchyma, practically no extravasation occurs because the fresh cut surface of the kidney promptly stops secreting. When the rupture extends into the renal pelvis some extravasation of course occurs, but here again, the injured kidney is badly discouraged and is usually kind enough to stop secreting for several days so that on the whole, even frank rupture of the kidney is seldom accompanied by much or grave urinary extravasation.

Intraperitoneal rupture of either the kidney, pelvis or bladder promptly results in peritonitis; moderately severe and consuming if the extravasating urine is sterile (which it usually is); very severe and fatal if the leaking urine is infected.

In a general way extravasation of urine in cases of rupture of the external urethra centers about the perineum, scrotum, penis, inner thighs and pubes. Extravasation of urine in cases of extraperitoneal rupture of the bladder or prostatic urethra centers about the front of the bladder in the loose space of Retzius where it appears as a deep supra-pubic tenderness and induration. Extra-peritoneal extravasation of urine in cases of rupture of the kidney is usually slight and readily absorbed. When not, however, it appears as a deep tenderness and induration in the renal region, occasionally burrowing down along the Psoas muscle to point in the groin.

RUPTURE OF ANTERIOR URETHRA

One of the commonest urinary tract injuries is that of rupture of the fixed part of the anterior urethra. This injury is classical and almost invariably happens in the same way. Heavy violence is exerted upward against the perineum crushing, by mere compression, the urethra against the under surface of the symphysis. This is the injury the school boy suffers when falling straddle a pipe fencing in front of the school. The laborer ascending his ladder falls astride one of its rungs with the same result. Again, as in one of my cases, a common drunk sprawled, open legged on the edge of the back seat, was thrown heavily forward when the car hit a telephone pole, lighting on his perineum against the inner back edge of one of the front seats. The type of violence is always the same; the injury the same.

In this classical type of rupture of the fixed urethra, the patient usually is not badly shocked. Signs of injury are apparent in the perineum; usually echymosis, at times actual open skin injury with some oozing of blood. Blood oozes from the meatus. Fortunately, the patient is usually unable to void and may be seen several hours later complaining principally of the misery of a severe acute retention when the distended bladder may be percussed, felt or seen extending above the pubis. A few less fortunate are able to void, at least to experience the sensation of bladder contraction, however, with a sharp stinging pain in the perineum and with little or no urine appearing at the meatus. In still another few, when the urethra is not actually divided and the cut ends retracted,

successful voiding may occur and without extravasation. If extravasation has occurred, the pain, swelling, and induration in the perineum rapidly increase and spread in all directions, in one of my cases even to the collar bones.

In the management of a case of ruptured urethra, the question of extravasation of urine is of prime importance. If extravasation has not yet occurred, it is essential that it be prevented. If extravasation has occurred, it is just as important that it be thoroughly drained and no further leakage permitted. Beyond this the main indication is the repair of the urethra with as little scar tissue as possible. With the presence of extravasation it seems best to sidetrack the urine by suprapubic cystotomy, to drain the extravasated regions by very free incision and to wait a week or ten days before picking up the cut ends of the urethra and making the end to end anastamosis. Without extravasation it likewise seems best to sidetrack the urine by cystotomy and wait several days before doing the urethral repair. I say this in spite of the fact that I have been successful in a primary repair of the urethra over a catheter to the bladder in cases both with and without extravasation. The temptation is all in favor of doing things that way but on the whole that is not the way which offers the best average result. To begin with the cut ends of the urethra are badly traumatized and do not heal as kindly as they do a week or ten days after the injury. To end with, absolutely successful catheter drainage of a bladder is a mighty hard thing to accomplish when relying upon the average intern. If the catheter clogs for a few hours and the patient voids around the catheter just once, the repair is very likely to break down and a less promising repair be made necessary later.

Some stricture is the inevitable result of this injury. In occasional cases the repair is so perfect that the scar is negligible but most patients will find the necessity of being sounded once or twice a year forever after the injury.

RUPTURE OF BLADDER

My series of cases of rupture of the bladder do not include a case of sword wound, a case of goring with a bull or a case of spontaneous rupture from over distention the result of inebriation. It may be that Milwaukee does not abound in either blades, bulls or beer. Most often bladder rupture in my experience has been the result of automobile injury. In one case a man was buried waist deep in a cave-in. In another instance a young boy fell from a high bank lighting stiff-legged, the femur crashing through the acetabulum. In all, the injury was one of violence to the bony pelvis with fracture at or near the pubic arch.

The patient with a ruptured bladder is often badly shocked, and badly injured elsewhere. Though possessed with an intolerable desire to void, his strainings bring nothing more than a few drops of blood. A catheter to the bladder finds it practically empty and if water is injected, little, if any, returns. There are external evidences of injury:—cuts, abrasions, hematomas, ecchymosis, swellings, and at times crepitation about the front of the pelvis. There is extreme tenderness and rigidity over the symphysis. If the rupture has been intra-peritoneal, there is general abdominal rigidity, pain in the epigastrium with nausea, and later distention with the typical picture of peritonitis.

In rupture of the bladder, the extravasation is the main point of importance. Suprapubic cystostomy must be done at once, the extravasation freely drained, and the bladder drained suprapubically by pezzer catheter or tube. The repair of the rupture will depend entirely upon its extent and location. As a rule it is neither necessary nor wise to give it any attention. It is either slight and will attend to itself or very extensive when it had better be left for a later date. Of course, peritoneal ruptures should be closed. They are usually small, clean cut, and easily repaired. The peritonitis is managed as usual.

The subject of renal injuries is well developed in the literature. Description is made of everything varying from the insignificant tear of perirenal fat to the fatal fracture of the renal pedicle. Injuries of the kidney fall into three main groups; those in which the parenchyma is fractured, with or without the capsule, those in which the fracture extends into the cavity of the kidney, and those in which the vascular pedicle is torn.

Injury to the vascular pedicle is exceedingly serious. The hemorrhage may be into the peritoneal cavity or may be confined to the loose perirenal space. The patient is usually in very profound shock from hemorrhage and if there is any help for him, it is usually that of being left alone. Occasionally the patient reacts sufficiently to permit operation 48 to 72 hours later.

Extensive rupture of the kidney continuing from the capsule through to the cavity in like manner presents a grave situation. Shock is also quite

profound. Here again the waiting of 48 to 72 hours is about the only thing that can be done for the patient. If sufficient reaction has occurred by that time, operation may be done and the rupture repaired or further hemorrhage controlled by packing, as the exigencies of the case may indicate. In spite of the fact that the renal cavity has been opened, urinary extravasation does not as a rule play an important part. Such injuries are so extensive that unilateral anuria has occurred and the few centimeters of urine that does leak out are promptly walled off and absorbed.

In injuries almost entirely limited to the extra-renal pelvis or the upper ureter, extravasation plays a more important part. Here hemorrhage is not such a factor. By the second or third day, sometimes as late as the second week, a deep abscess develops in the renal region or possibly in the groin and, when drained, is found to be essentially urine.

Ruptures confined to the parenchyma of the kidney, especially when the capsule is not torn, are relatively mild afflictions, particularly if the patient is not subjected to operation. There is no extravasation of urine. A small hematoma may occur but it is absorbed without incident. More or less shock also accompanies this injury but within twenty-four hours the patient has usually reacted well and goes on to complete recovery.

While considering these various types of more severe injury to the kidney, sight must never be lost of the fact that there is a very large number of accident cases in which the renal injury amounts to nothing more than a concussion or, at most, an inconsequencial parenchymal fracture. Many of these patients present themselves in more or less profound shock from the fear and excitement of the accident or from injuries elsewhere. Especially if there has been external violence over the renal region, there is tenderness and rigidity in that location. The urine is often just as bloody as in the case of more severe renal damage. Unless injured badly elsewhere, 48 to 72 hours of waiting will see such a patient well and about ready to leave the hospital. Of course in those patients showing a steady increase in pulse with drop in blood pressure it soon becomes evident that hemorrhage, unless controlled, will result in death. Under such circumstances, operation must be done at once if any hope is held for the patient's recovery.

The very great majority of renal injuries occur following the same general type of accident. The injury usually results from a heavy bodily impact such as falling from a height, being struck by an automobile, or as in one of my cases, being thrown bodily against a tree while coasting. There is usually nothing about the severity of the accident that gives any hint as to the extent of renal damage. I submit a pyelogram of a case of subcapsular renal fracture. (Fig. I.). This occurred in a man who bounced down through six floors of

scaffolding and suffered, among other things, nine bone fractures.

In a similar way there seems to be no consistent relation between the degree of renal damage and the extent of injury to the over-lying soft and bony structures. A fatal case in my series failed to show any skin abrasion except over one of the scapulae.

In like manner the degree of shock, the local rigidity and tenderness and the hematuria give little dependable information as to the type or extent of renal injury. In the case the pyelogram of which you have seen, the shock was very profound, there was board rigidity over the entire side and back and the urine was thick with blood. During the first twelve hours no one held the least hope for him but, except for his bone fractures, he might have left the hospital at the end of the week.

With the subject of renal injuries so beset with difficulties in diagnosis; with the degree of injury such a matter of speculation; and especially with shock so consistent and profound, there seems little need of argument as to the procedure in handling these cases. Certainly it would seem that immediate surgery should be out of the question except in the most unusual instances. Expectant treatment for forty-eight or seventy-two hours offers as low, if not lower, mortality than immediate interference. It does far more than that, however, in that it permits the great majority of these cases of renal injury to be up and out of the hospital in much the shorter time.

Ultraviolet Light and Nutritional Disturbances

By G. J. WARNSHUIS, M. D.
Milwaukee

Underlying every disease whether it be an acute infection or a chronic, degenerative change, a disturbance of nutrition, a lack of normal vitality in some part of the cellular units of the individual, exists. The association of this imperfect metabolism with the symptoms of the disease may not always be apparent and may appear only as an indirect cause. In any event we are not justified in ignoring it.

The precise nature of such nutritional disturbance is not always amenable to analysis. Profound disturbances can be influenced in some degree by the character of the food ingested. In most cases, however, the deficiency is brought about by an inability to assimilate and metabolize the alimentation offered. Such impairment may manifest itself by definite morphological changes such as loss of weight or failure to maintain growth, or it may result in functional disorders and a predisposition to certain infections.

Thirty years ago little was known about intermediate metabolism. Today, a knowledge of acid-base equilibrium, endocrine function, and the relation of the inorganic constituents of the body fluids to cell activity is essential in the proper treatment of morbid processes.

Since it has been found that irradiation of the surface of the body with ultraviolet energy has an important influence on all three of these factors in metabolism and is a therapeutic agency for which there is no adequate substitute, it is necessary that we discuss it from the standpoint of its precise physiological effect rather than the claims of indiscriminate enthusiasts or the condemnations of uninformed critics.

The effectiveness of ultraviolet radiation in curing rickets is one of its best known properties. This was recognized long before the true nature of rickets was understood. Now that rickets may be classed as a true deficiency disease such as scurvy, beriberi, and pellagra and is directly associated with a lack of vitamine D it is not difficult to understand why the results of its treatment with ultraviolet light should be so striking.

So much emphasis has been placed on the effect of ultraviolet light on calcium retention that a great many are likely to lose sight of the fact that the improved calcium fixation is a secondary effect resulting from a changed blood chemistry in the presence of an adequate supply of vitamine D. Rickets may develop in the presence of a normal blood calcium content and, in fact, usually does. The ability of the fixed tissues to assimilate it, however, will depend on the presence of vitamine D.

Some of this action of vitamine D on mineral metabolism may be attributed to its effect on the parathyroid function. Humphris has shown, for example, in his experiments with ultraviolet light on rabbits that there was a definite increase in the weight of all the endocrine glands and in the parathyroids an increase of 51.2% could be demonstrated.

While it appears rather remarkable that such grave disturbances as rickets and infantile tetany can result from such a simple cause it is not so strange if we only reflect on the tremendous influence light rays have on chemical changes. The ultraviolet rays that produce these vitamines, split the oxygen molecule into a most active and explosive combination called ozone, and cause light sensitive compounds to fluoresce, differ only in a small degree from the x-rays that are able to coagulate animal proteins and the radium emanations that are capable of breaking up the atom itself.

Indeed, far from wondering at such results, a study of the electro-magnetic nature of light would lead us to look for evidences of many other metabolic changes that may be influenced in a similar manner. This brings us into the study of other vitamines and their effect on metabolism and organic function as well as the other effects besides rickets and infantile tetany that follow from a deficiency of vitamine D. Space does not permit a proper discussion of this, and if we have succeeded in outlining the basis of ultraviolet action on nutrition we feel that one real purpose at least has been accomplished.

THE JOURNAL CLINIC

Abscess of the Frontal Lobe Complicating Frontal Sinusitis: A Case Report*

By WILLIAM S. MIDDLETON, M. D.
Madison

Whereas abscesses of the brain secondary to purulent otitis media and mastoiditis are relatively common, involvement of the frontal lobe secondary to a purulent infection of the frontal accessory sinuses is very unusual. Contrary to Gerber's statement that "the common symptom of frontal lobe abscess is its absence of symptoms," the following case presented a characteristic sequence of events and findings which admitted of no other interpretation. It is reported in some detail because of the ultimate application of such data to the conclusion.

Case—R. K., an adult, white, male student, was admitted to the University Infirmary on March 7, 1923, complaining of "soreness in the head".

H. P. I.—Succeeding a nasal cold of four days' duration, the patient first developed frontal discomfort yesterday. This discomfort is described as a soreness and the existence of headache is emphatically denied. Accompanying this soreness, which is localized above the left eye and in the left cheek, there has been much nasal secretion. A slight sore throat, present at the onset, has now subsided.

Physical Examination—Reveals acute tenderness over the left frontal and maxillary sinuses. Much muco-purulent discharge from left nostril. The throat is diffusely red. Chest—the lungs show only prolonged respiration with few fine crackling rales beneath the angle of the right scapula. The heart shows no enlargement. A soft systolic murmur is heard at the apex.

Otherwise the physical examination is negative.

March 8, 1923—Much crusting is noted in the left nostril with abundant secretion. Tenderness over the left antrum and frontal sinus persists. Nasal culture shows staphylococci and streptococci. Urinalysis is not significant.

March 9, 1923—With an accession in drainage the local and general conditions are improved.

March 10, 1923—More uncomfortable. Headache in left frontal area. Fine crackling rales are heard in showers in right base posteriorly. Nasal culture is again reported as showing staphylococci and streptococci.

March 18, 1923—Discharged, having completely subsided.

On May 2, 1923, he is readmitted, stating that there had been no real cessation of his sinus complaint since discharge from the Infirmary. The headache and frontal tenderness have been particularly acute for the past two days. Drainage has continued with little change since leaving the hospital.

Physical examination shows marked bogginess of the mucous membranes of nose. Much muco-pus. Eyes—pupils round and equal, react to light and accommodation. Fundi show indistinct nasal margins to the nerve heads. The choroid and retina appear normal. These changes, it is noted, may be explained by a refractive error. Nothing further of note is remarked on physical examination.

X-rays of sinuses do not reveal dense clouding suggestive of pus.

May 5, 1923—Pupils react normally. No stiff neck nor Kernig noted. Lumbar puncture shows fluid under increased pressure. 20 cells per cu. mm. Gold sol, 2222100000. Wassermann negative. W. B. C., 16,000, but with a normal differential distribution.

*From the Department of Medicine, University of Wisconsin.

May 8, 1923—The local and general conditions are the same. W. B. C., 18,800.

May 9, 1923—After an apparent improvement, the patient has become very stuporous and apathetic. Headache has recurred bifrontally. The tongue is heavily furred. There is tenderness over both frontal bosses. The spleen is enlarged. No stiff neck nor Kernig. Blood culture (48 hours) negative. W. B. C., 28,600.

May 10, 1923—The patient continues stuporous and irritable when aroused. No neurologic findings of pathologic significance. Lumbar puncture shows fluid under somewhat increased tension. Blood tinged, so that only Wassermann was made. This was negative.

May 11, 1923—Reflexes are hyperactive. No cranial nerve involvement. Tache cerebralé. Suggestive fanning of the toes on plantar stimulation of the right foot.

May 12, 1923—W. B. C., 13,600.

May 14, 1923—Right biceps jerk is somewhat more prompt. Marked stupor. Spinal fluid culture (72) hours, no growth.

May 15, 1923—W. B. C., 12,800.

May 16, 1923—There has been a progressive muscular wasting in all extremities. Almost normally alert this morning. No abnormal neurologic findings are noted. Slight fluffiness and oedema of nasal margin of left disc.

May 17, 1923—W. B. C., 10,200. More lethargic than for some time. Vomited after the evening meal.

May 18, 1923—Although clearer mentally, there is some stiffness of the neck. Abdominal reflexes on the right are lost.

May 19, 1923 — Bilateral hyperreflexia in lower extremities. Indefinite Babinski on the left. Lumbar puncture revealed a clear fluid under increased tension. Cell count, 30 cells per cu. mm. (Polys. 46%; lymphocytes 54%). Wassermann negative. Gold sol, 4443210000; Ross-Jones faintly positive; Noguchi, positive. Fluid showed no pellicle and was culturally sterile.

May 21, 1923—Progressive improvement. No pathologic reflexes. Wasting more apparent. Occasionally in past few days has vomited after the suggestion of food.

May 26, 1923—Abdominal reflexes present. Eye ground examination revealed some progression in the blurring of outlines of discs, left greater than right.

June 6, 1923—Discharged to home.

On three occasions during the first week of this second residence the temperature rose to 99.4; the pulse ranged from 56 to 88 and the respirations from 16 to 20. The urine was repeatedly negative for pathologic findings.

R. K. is admitted for the third time on November 15, 1923, in a confused state with the history of an unusual circumstance occurring last evening. Early in the evening the patient was found unconscious in his clothes closet. After a time he aroused, spoke rationally to his friends and then apparently fell to sleep naturally. This morning he could not be aroused. He vomited several times. On admission he complains of severe headache but remains quite stuporous.

While being examined the patient develops twitching in the left pectoral muscles succeeded by a guttural cry, rigidity of the neck, grinding of the teeth and a generalized clonic convulsion initiated in the right arm.

Physical examination is of necessity incomplete but reveals general hyperreflexia, with more prompt response on right, and a suggestive Kernig. The temperature registers 102.8° F.; the pulse is 120 and respirations 28. W. B. C., 23,200. Polymorphonuclears, 92.8; lymphocytes, 7.2.

Convulsions were repeated during the day, seven times prior to a lumbar puncture. Lumbar puncture was performed at 10 A. M.—fluid under greatly increased tension, slightly blood tinged.

Ten cubic centimeters of 15% magnesium sulphate were administered intravenously at 11:45 A. M.

November 16, 1923—Patient states that he feels much relieved. Has been much quieter since the injecting of magnesium sulphate. Up to 10:10 P. M. there have been but two convulsions since noon yesterday. Blurring of nasal margins of both discs. W. B. C., 14,400.

Recurrence of convulsions in rapid succession this evening lead to the repetition of magnesium sulphate intravenously without avail.

November 17, 1923, 9:30 A. M.—Over twenty major convulsive seizures have occurred since 10 P. M., November 16th. These attacks are becoming more localized to the right side of the face and during the convulsions the eyes twitch sharply to the left. Abscess of the left frontal lobe was diagnosed.

1 P. M.—A left temporal decompression was performed by Dr. Joseph Dean at St. Mary's Hospital. The dura did not bulge and exploration did not reveal an abscess.

November 18, 1923—Patient died at 6 A. M., following a period of aphasia. The convulsions continued on the right side of the face until death.

A partial necropsy was permitted and at this time there was determined a pin-head sized perforation through the frontal plate into the left frontal sinus. The meninges were adherent at this point and an inflammatory thickening of the dura with adherent pia-arachnoid extended for 1 cm. in all directions from this point of perforation. A zone of softening was determined in the tip of the left frontal lobe. Section of this region revealed a pultaceous gelatinous change involving a zone 3 cm. in diameter.

This case then presents the clinical sequence of a purulent frontal sinusitis, perforation of the inner plate of the frontal bone, localized meningitis and abscess of the frontal lobe. The persistence of the frontal headache had led to a suspicion of this complication at the time of his second period of hospitalization. More than six months prior to the fatal termination indefinite changes had been remarked in the nerve heads. Repeated spinal fluid studies had determined unexplained changes particularly in the gold sol curves. A period of lethargy sufficient to suggest encephalitis epidemica supervened. Disposition changes were questioned. Fleeting and inconclusive neurologic findings marked the first two periods of observation. Then after a lapse of five months there suddenly appeared the unmistakable evidences of localization to the left cerebral hemisphere and the antecedent

history left little question as to the probable origin of these localizing signs.

Abscess of the frontal lobe secondary to a frontal sinusitis most commonly occurs as a sequel to an osteomyelitis of the compact posterior bony wall. Extradural abscess is the rule and in turn a subdural or a brain abscess may arise by continuity. Intimate vascular communications exist between the frontal bone and the dura overlying the frontal lobe. By reason of this relation at the frontal tips a ready route of infection is suggested. The tip of the frontal lobe furthermore receives its blood supply through a loop from the anterior cerebral artery rendering its resistance to infection relatively low. The natural courses of the optic nerve and the ophthalmic vein may constitute passages for an infection. The lymphatics and lastly dehiscences, congenital or acquired, may offer paths of invasion to a frontal sinus infection. Skillern holds that the danger of intracranial complications from frontal sinus infections is greater in the male, in older individuals and on the left side.

Leegaard has ably reviewed the literature on this subject, and from these sources and his own experience outlines the course into four stages, initial, latent, manifest and terminal. Since osteomyelitis of the anterior plate of the frontal bone usually precedes involvement of the more dense posterior plate, edema of the eyelids may be anticipated. Particular attention is directed to the essential absence of focal neurologic symptoms until there is an extension of the process posteriorly with motor center involvement. Evidences of increased intracranial pressure are not commonly observed. The reputed significance of psychic changes is often misleading in his judgment. Lastly he stresses the intensity of the headache; and he advises that in operating for the relief of the affected sinus, a failure to alleviate the agonizing headache should indicate the necessity for intracranial surgery. In the temporo-parietal zone the finding of an extradural accumulation of pus obviates the need for further investigation, but in the frontal region it is a prime indication for opening the dura. From the standpoint of diagnosis, the notorious "silence" of the frontal lobes and the latency of symptoms in frontal lobe abscess must always be borne in mind.

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Diagnostic Problems

By L. M. WARFIELD, M. D.
Milwaukee

In the last issue we had the case of a perfectly healthy boy of 16, who within 48 hours develops complete paralysis of his arms and legs, no loss of sensation or of consciousness. Condition stationary for over two weeks.

DISCUSSION

I bring this case to the attention of the Journal readers because of its very unique character. The diseases which might conceivably produce this picture are: 1, Landry's paralysis, 2, multiple neutitis, 3, anterior-poliomyelitis, 4, encephalitis, 5, acute infectious polyneuritis.

Multiple neuritis seemed to be ruled out in this case because of the extensive character of the paralysis and the complete absence of all disturbances of sensation. There was no history of carbon-monoxide poisoning nor any history of other poisons which might have been responsible for the condition. In the absence of all sensory disturbances as well as fever one can scarcely diagnose this as multiple neuritis. In anterior-poliomyelitis the characteristic of the paralysis is the suddenness of its onset. The child is slightly ill and suddenly is unable to use an arm or a leg or both legs. Further there is fever, there is usually backache, often some gastro-intestinal disturbance and the spinal fluid shows an increased number of cells. When one considers the pathologic picture of anterior-poliomyelitis; namely the infiltration around anterior horn cells of the spinal cord it is inconceivable that this disease could be poliomyelitis. Could this be the spinal form of epidemic encephalitis? Here again the pathologic picture is much like that of anterior poliomyelitis, and to have this peculiar progression of paralysis without any cranial nerve lesions

of any kind, if one excepts the unusual nystagmus, would seem to be so unusual as to be practically an impossible diagnosis.

All of us have seen many forms and onsets of encephalitis. Recently I was told of a case where apparently the diaphragm was the first muscle involved and now two years later the individual has a typical Parkinsonian syndrome. However, this paralysis was slowly progressive, taking 48 hours to reach its height and there it stopped, so that I personally do not feel it is encephalitis we are dealing with. It may be a peculiar form of polyneuritis which was described during the war. Many cases were seen in France during the attack of influenza. This is possible, although not having seen a case of this disease personally I am not at all sure. This leaves practically nothing but Landry's paralysis as the most probable diagnosis. There is no question here of post diphtheritic paralysis. Yet here again while this conforms in every particular to the descriptions of Landry's paralysis and to the physical signs obtained, the course of the disease is quite unusual. By this time the patient should be dead. However, there are cases reported of paralyses of this nature in which recovery took place, and as we do not know anything about the pathology of Landry's paralysis (certain people considering it to be a form of poliomyelitis and others denying this), this may be one of those unusual forms in which death does not ensue within a few days of the onset of the paralysis.

Our tentative diagnosis, therefore, is Landry's paralysis, although we must confess that it is the diagnosis by exclusion which does not altogether satisfy.

ADDENDA

October 20: The condition of the patient is slowly improving. X-ray of the spine was negative. He is bright and cheerful mentally.

A NEW PROBLEM

On December 1, 1919, I was consulted by a man, aged 50 years, an iron worker, who complained of a tumor mass in his side.

There is nothing of importance in his family history, and although he had never been a particularly strong man he had worked up to a week before he consulted me, at his trade. Many times, however, he had forced himself to go to work. In the past 10 years he had gradually lost 25 pounds. For many years he has had red cheeks and nose and very tender skin. He also has had several attacks of iritis in the left eye and rheumatic pains in the knees. He had never had tonsillitis. For the past 18 months his left eye had bulged somewhat. It was slightly improved when he was seen but was still bulging. His appetite had been good, his bowels were regular and he had no urinary disturbances. About 6 weeks before he was seen he noticed a dragging pain in his abdomen. He found a mass in his left side and was told it was the spleen. In September he had some kidney attack with blood in his urine. There were no other facts of particular interest.

On examination he was an emaciated man, his cheeks and nose were covered with dilated venules. He had no teeth and his tongue was red. The left eyeball was bulging, with the pupil smaller than the right, reacted normally with no increased intra-ocular tension. There were no glands palpable. The chest was long, narrow, with thickened pleura on the left side. His heart was normal. There was marked arteriosclerosis. In the abdomen there was bulging in the upper left quadrant due to the spleen which was somewhat hard, and extended as far as the level of the navel and almost to the midline. The liver was not felt. The urine showed a slight amount of albumin, no sugar. Microscopically it contained considerable pus and a few red blood cells but no casts. There was no urobilinogen. The blood count was 90% hemoglobin, 5,792,000 reds and 32,600 leukocytes. In the stained specimen there were myelocytes, one of which was an eosinophilic myelocyte. No complete differential count was made at that time.

All track of the patient was lost until August 5, 1927 when he was admitted to the Milwaukee County Hospital, complaining of an enlarged spleen, weakness, and inability to retain solid food for the past 6 weeks. He had apparently been working up to June, 1927, gradually losing weight and becoming weaker during the past year, so that he finally had to give up work entirely. In the last three months he had lost considerable weight. He has had no vomiting of blood or blood in his stools. His whole complaint has been a gradual and progressive weakness.

On physical examination by the hospital interne there was noted a slight icteroid tinge to the sclerae, palpable glands on the right side of the neck and an abdomen which was distended and tender to the touch. The spleen was enormously enlarged and smooth except at the inferior border

(Continued on Page 598)

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SERVICE AVAILABLE

In this space each month will be set forth the essential details of each of the fields of service to the members developed by the State Medical Society. It is the hope that these short articles will prove of value to the reader.

MEDICAL LIBRARY SERVICE

Dean Snell of the Extension Division announces the appointment of Miss Frances Van Zandt as full-time librarian for the medical library service. While the package library service to physicians was organized some time ago under Miss Almere Scott, director of the Department of Debating and Public Discussion in the University Extension Division, the securing of Miss Van Zandt means that the work will be greatly expanded, for before coming to Wisconsin, Miss Van Zandt developed the highly successful medical library service connected with the Iowa state library. This project at the University of Wisconsin is the first medical extension library service in connection with a state university.

The Medical Library Extension Service at Madison is now prepared to send out upon request: (1) Medical textbooks and reference books dealing with special topics; (2) periodicals; (3) collections of reprints, packet library, dealing with special topics; (4) brief abstracts of the literature dealing with special topics; (5) preparation of bibliographies dealing with special topics. Dean Snell explained that no charge is made for this service except the postage both ways on the loaned material. The period of loan is two weeks, except for current journals, with the privilege of renewal. Lists of available books and periodicals will be sent upon request. *All requests should be addressed to Miss Frances Van Zandt, Medical Library Service, University of Wisconsin, 412 North Charter Street, Madison.*

The University Medical School and its library, through Dean C. R. Bardeen, is cooperating in every way in carrying on the expanded medical extension services according to Dean Snell, who anticipates greatly increased correspondence from physicians of the state who wish to inquire about these newly available services. It is expected that the medical extension library will be of very great service, particularly to physicians in the smaller towns and rural districts.

EDITORIALS

LIABILITY FOR X-RAY BURNS

NEXT to fractures, x-ray burns occurring in connection with the employment of x-rays for diagnosis or treatment have heretofore been the most frequent basis for malpractice suits brought against physicians. The occurrence of a burn from the employment of x-rays seems to have been regarded as evidence of carelessness or neglect on the part of the physician, and suits brought on this basis have been particularly difficult of defense and very likely to result in a judgment against the physician.

A recent decision of the Supreme Court of Wisconsin in the case of Kuehnemann vs. Boyd is of particular interest to physicians who use the x-ray for diagnosis or treatment. The Court, in this case, laid down the principle that . . . "it was the defendant's duty to exercise that degree of care, diligence, judgment and skill which physicians in good standing in the same school of medicine usually exercise in the same or similar localities, under like or similiar circumstances, having regard to the advanced state of medical or surgical science at the time he has discharged his legal duty to his patient . . . We can see no reason why the same rule should not apply to x-ray treatments given by a physician to a patient for curative or healing purposes. The discoveries of science are continually placing in the hands of physicians new agencies with which to cope with disease. Among such discoveries came the x-rays . . ."

The Supreme Court's decision apparently places the physician's liability for x-ray burns upon the same basis as any other diagnostic or therapeutic procedure he may employ and removes the assumption that the occurrences of a burn is of itself evidence of carelessness or ignorance on the part of the physician who employs the x-rays in the diagnosis or treatment of disease.

J. F. S.

HONORING OURSELVES

THE laying of a wreath on the grave of J. V. R. Lyman, a former President of the Wisconsin State Medical Society, at the recent Eau Claire meeting, was a fitting tribute to a rare physician and a rare man. One of his neighbors—not a physician but one who knew Dr. Lyman quite intimately—said after the ceremony that John Lyman was easily their foremost citizen.

It has become a common thing, on such occasions, to say that in honoring such as he, we honor ourselves. Indeed, the expression has become so trite that the deep underlying truth of the expression is obscured rather than illuminated by it. And yet, in the eyes of that fellowcitizen referred to, and in those of many other of John Lyman's friends and neighbors, we were most positively bringing honor to our profession when we honored their friend and their beloved physician.

H. E. D.

YOUR OFFICERS

DURING November and December most of the county societies will choose their officers for the coming year. Each series of elections in late years has recorded, by its results, a new and wholesome tendency in elections.

The time has long since past, if indeed it ever existed, when the offices of a county medical society constituted an honor to be bestowed in rotation; or a reward to be received. The realization is here that the county medical society is the very foundation of the state and national organizations. More and more do we appreciate that no state society can be strong without strong county medical societies. And numbers of members alone do not necessarily mean strength.

In numerous societies visited at election time we have been impressed by the evident realization of the members that the offices to be filled were each opportunities for constructive work and that the honor came only as result of doing good work during the term of office. It is no longer a case, for instance, of Dr. Jones nominating Dr. Smith as delegate because Dr. Smith is a good fellow. Today we find the President suggesting that before a delegate is elected he would like to see the hands of those who expect to attend the next annual meeting of the state society. Then when the state society meets, the roll call of the house of delegates shows a representative for that county medical society.

Frequency of meetings, strength of programs, proper cooperation and leadership in public health problems, solution of economic phases of professional life,—all these and more are responsibilities of the officers and those who discharge them ably merit the honor and appreciation of the membership. All of which may be summarized by saying that the cloak of office comes at election time but the honor is not given until the annual report is made.

FREE MEDICAL SERVICE—ARE THERE ANY REMEDIES?

THE President of the Wisconsin State Medical Society states that "Eight million of our people were treated gratuitously in the free clinics and hospitals last year." He describes some of the patients frequenting dispensaries and free clinics as clad in furs and other finery and driving up in taxi cabs or palatial cars.

We assume that his figures apply to the whole country and even so it would mean that approximately one out of about every fifteen persons secures medical attention at dispensaries and clinics for nothing or at low rates, thereby depriving physicians of legitimate incomes. The wonder is that the medical profession is as complacent as appears to be the case, for in addition to this great loss in income most doctors are contributing free service to an unduly large proportion of patients in private practice. Millions of dollars could be contributed to the income of doctors who need this added revenue if the profession would unite in protest to the boards in charge of charitable medical institutions. The writer happens to travel in a conveyance which is used by a large number of attendants upon the clinics of one of Boston's large hospitals, and some of these people present external evidence of being in comfortable circumstances, so that the comments of the President of the Wisconsin Society are probably based on facts.

We deplore the tendencies of the times to exploit the medical profession, but we suffer almost in silence. Occasionally a voice is raised in protest but no concerted action results. The doctors in charge of the clinics find excellent opportunities for study and experience, and cannot be expected to analyze the financial status of patients. This should be a responsibility of the hospital management, but fairness demands recognition to the difficulties inherent in dealing justly with the various human elements in the crowds appealing for service in large clinics.

If every state medical society would employ an efficiency expert to study the abuses heaped upon the profession and formulate plans for correcting these evils, both the people and the patients would be better off. This, of course, involves expense, but some doctors might be willing to pay larger annual dues if wise expenditure of money brought corresponding benefits.

We pay our taxes to have the protection of fire and police departments and the general comforts and advantages of libraries, schools, etc. We may well learn a lesson from some of the cults for it is reported that certain organizations of these classes pay large assessments for propaganda and appeals for recognition by legislatures.

The changing conditions of society will compel the medical profession to take cognizance of certain matters outside the routine of practice, for community responsibilities imply cooperation with others of equal ability in maintaining standards of living. Doctors cannot live in garrets, and they owe to their dependents the advantages of education and comfortable surroundings.

Collectively and individually in common with other workers medical men need that assurance of success which may in many instances depend upon judicious propaganda.

In matters of law and finance the doctor should depend on expert service. In the broad functions of society activities and public education we need capable representatives.

As a class we are poor advocates, untrained in debate and unfamiliar with political maneuvers. Most of us would be better off if we applied ourselves closely to the duties of the hour and contributed funds to the society which could be applied in perfecting our organization by employing those who have qualities of leadership.

Unless we are ready to spend money we will see ourselves distanced in the race.

We do not suggest maintaining lobbies or paying for votes but we feel that intelligent and loyal service may be secured at reasonable rates which will direct and supplement voluntary unpaid work. This is a subject worthy of debate.

(Editorial, Boston Medical and Surgical Journal, Sept. 15, 1927.)

THE PRESIDENT'S PAGE

Arthur W. Rogers

FROM THE CHAIR

MOST of you are familiar with the well known cartoon appearing at intervals in a Chicago Daily, "Wonder what a waiter thinks about?", etc. The theme of this cartoon was forcibly impressed upon our mind during a recent meeting of physicians in the upper part of the state. We wondered but shall never know what the audience thought about, but the audience is now to learn some of the things that the chairman of that meeting thought about.

First, we wondered why men attend medical meetings. The small voice said: "Why, don't you know that a limited number do so for their own aggrandizement; another group go for social purposes; and still another to observe what their fellow practitioners are saying and doing. From the chair the last state medical meeting seemed to be composed almost exclusively of this last group. The chair observed more than a sprinkling of men who seldom attend the state meeting. They said that they came because the program interested them and that they believed it had been prepared to interest the largest group in the Society. The chair knew that men in special lines of work had their own societies to serve them. Theodore Roosevelt once said: "I believe that every member of an organization is in duty bound to give some of his time and thought to the betterment of that organization." Believing this, then it devolves upon every member to make every possible effort to attend the meeting of his state society. Its work and improvement reflects on each individual member.

The chair was further impressed with the happy selection of the assembly hall so devoid of all outside noises that both speaker and audience were protected from the customary annoyance. The acoustics could not have been better. The chair had never attended a meeting where the members were so courteous in preventing disturbances from the inside.

The chair observed on the speaker's platform a contrivance, new to him, to control the over voluble speakers, but it was never necessary to call this into use. The papers were all snappy and with one exception no speaker over ran his allotted time. This was indeed an innovation. One thing was lacking —a free discussion of many excellent papers, which in the future might be avoided by designating gentlemen to lead the discussion.

All the above may impress some as somewhat self decorative, but we believe that most of those who read this will attribute a more generous motive in our attempt to improve our future meetings.

We cannot refrain, at this time, from expressing our personal appreciation of the excellent work of the arrangement and program committees, and especially the ladies of Eau Claire for the attention and entertainment given the visiting ladies.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

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Barron-Polk-Washburn-Sawyer-Burnett	H. M. Coleman, Barron	D. L. Dawson, Rice Lake.
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Dodge	L. M. Bachhuher, Mayville	A. A. Hoyer, Beaver Dam.
Door	John Hirschhoeck, Forestville	T. C. Proctor, Sturgeon Bay.
Douglas	P. G. McGill, Superior	J. W. McGill, Superior.
Eau Claire and Associated Counties	G. W. Beehe, Eau Claire	H. M. Stang, Eau Claire.
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Green	Edward Blumer, Monticello	J. F. Mauermann, Monroe.
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Lincoln	E. K. Morris, Merrill	W. H. Bayer, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	M. P. Andrews, Manitowoc.
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Milwaukee	C. H. Stoddard, Milwaukee	E. L. Tharinger, Milwaukee.
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Oconto	C. W. Stoelting, Oconto	C. J. Ouellette, Oconto.
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Waupaca	T. E. Loope, Iola	A. M. Christofferson, Waupaca.
Winnebago	S. D. Greenwood, Neenah	R. H. Bitter, Oshkosh.
Wood	J. C. Hayward, Marshfield	V. A. Mason, Marshfield.

SOCIETY PROCEEDINGS

DANE

At the regular monthly meeting of the Dane County Medical Society, held on October 11th at the Kegonsa Hotel, Stoughton, Dr. R. A. Barlow, Madison, addressed the group on "Pathology in Ear, Nose, and Throat Conditions Due to Vitamine Deficient Diet." Dr. H. M. Carter, Madison, gave an interesting paper on "Appendicitis in Children." *H. H. R.*

GRANT

The 25th anniversary meeting of the Grant County Medical Society was held at the Grantland Club Rooms, Lancaster, on Monday, October 24th. A notable program celebrating the event was presented. The speakers included: Dr. Harold Marsh, Jackson Clinic, Madison, "Medical Impressions of Vienna"; Dr. Ira Sisk, Madison; Dr. O. B. Nugent, Chicago, "The Eye in Relation to General Medicine"; Dr. Wm. J. Mayo, Rochester, "The Relation of Pure Science to Medicine"; and Dr. J. W. Gale, Madison, "Cancer of the Breast."

A 6:30 banquet was served in the club rooms to the members and guests. The meeting was considered one of the most interesting and instructive sessions ever held by the Grant County Society. *M. B. G.*

KENOSHA

The Kenosha County Medical Society met on September 23rd at the Elks' Club. Dr. Kellogg Speed, of the Presbyterian Hospital, Chicago, spoke on "Unhappy Results in the Treatment of Fractures." The talk was illustrated by lantern slides and was very instructive. *H. A. B.*

ROCK

The Rock County Medical Society opened its fall season with a meeting at the Janesville Y. M. C. A. Tuesday evening, September 27th. Dr. E. A. Fletcher, Milwaukee, was the speaker of the evening following the dinner. He discussed the urological clinics of Europe with special reference to the Marian Clinic of Paris, France. Dr. Fletcher prefaced his talk by a brief historical outline of France.

Dr. Carl Neupert gave a report on the joint picnic of the Winnebago (Illinois) and Rock County Societies held during the summer. *H. E. K.*

WAUPACA

The members of the Waupaca County Medical Society met at the Public Library, Waupaca, on Thursday evening, September 15th. Dr. Joseph F. Smith, Wausau, presented a paper on "Abdominal Surgery," which was followed by a general discussion. The meeting was well attended. *A. M. C.*

SECOND COUNCILOR DISTRICT

The members of the Second Councilor District Society and their wives spent Thursday, October 13th, at the Kenosha Country Club. Dr. Edward Miloslavich, Milwaukee, spoke on "Hypernephroma of the Kidney" and Dr. B. H. Nichols, of the Crile Clinic, Cleveland, presented a paper on "Roentgenology of Gall Bladder and Appendix." Following discussion of these papers those in attendance enjoyed a dinner and entertainment.

At the business meeting following the dinner Dr. B. J. Bill, Genoa City, was elected president of the district society, and Dr. T. P. Keenan, Lake Geneva, secretary. *H. A. B.*

PIERCE-ST. CROIX

The October meeting of the Pierce-St. Croix Counties Medical Society was held in the Legion Hall at River Falls on the 12th of the month. The scientific and business session was preceded by a 6:30 supper. The program consisted of a paper by Dr. C. A. Stewart, of Minneapolis, on "The Present Status of Treatment of Contagious Diseases," and a paper by Dr. E. L. Boothby, of Hammond, on "Treatment of Enuresis."

The following officers were elected for the year 1928: Dr. O. H. Epley, New Richmond, president; Dr. A. D. Ford, Roberts, vice president; Dr. J. W. Prentice, Deer Park, secretary-treasurer; Dr. C. A. Dawson, River Falls, censor; Dr. J. W. Prentice, Deer Park, delegate to state meeting, and Dr. Rolla Cairns, River Falls, alternate. Dr. E. L. Boothby, of Hammond, was elected president emeritus. The next meeting of the society will be held at New Richmond on November 16th. *J. W. P.*

AMERICAN UROLOGICAL ASSOCIATION

The fourth annual meeting of the North Central Branch of the American Urological Association was held at Madison on October 14th and 15th. The following program was presented: Dr. Charles R. Bardeen, Dean of the Medical School, "Address of Welcome"; Dr. W. E. Sullivan, Professor of Anatomy, "The Lobulated Mammalian Kidney"; Drs. I. R. Sisk and J. Supernaw, "Variations in Excretion of Phenolsulphonephthalein"; Dr. A. S. Loevenhart, Professor of Pharmacology, "Newer and Safer Local Anesthesia"; Dr. E. L. Sevringhaus, Associate Professor of Medicine, "The Rate of Excretion of Urea"; Dr. M. Waters, Attending Anesthetist, Wisconsin General Hospital, "Ethylene and Nitrous Oxide Anesthesia in Urological Surgery"; Drs. I. R. Sisk and W. S. Beyer, "The Effect of Morphine on the Function of the Normal and Pathological Kidney." Following the morning program luncheon was served at the Wisconsin General Hospital.

The afternoon program: Dr. Wm. J. Carson, Milwaukee, "Solitary Cysts of the Kidney; Report of Cases"; Dr. Walter M. Kearns, Milwaukee, "Alkaline Incrusted Cystitis, Urethritis and Prostatitis"; Dr. Parke G. Smith, Cincinnati, "Carcinoma of the Kidney"; Dr. Gustav Kolischer, Chicago, "The Pyelitis Question"; Dr. John L. Crenshaw, Rochester, "Case Reports"; Dr. Frederic E. B. Foley, St. Paul, "Demonstration of New Cysto-Urography Table." Dr. E. O. Smith, Cincinnati, spoke on "Interlocking of Urology and Neurology" and Dr. Herman L. Kretschmer, Chicago, on "Urology in Children" following the evening banquet at Hotel Loraine.

Those presenting papers on Saturday morning were: Dr. Verne C. Hunt, Rochester, "Posterior Excision of the Seminal Vesicles"; Dr. Frederic E. B. Foley, St. Paul,

"Uretero-Ureterostomy as applied to Obstructions of the Duplicated Upper Urinary Tract"; Dr. Gilbert J. Thomas, Minneapolis, "Some Points in the Technique of Pre-Operative and Post-Operative Treatment of Benign Hypertrophy of the Prostate"; Dr. E. Z. Shapiro, Duluth, "The Diagnosis of Renal Tuberculosis." *H. M. S.*

GREEN BAY ACADEMY

A meeting of the Green Bay Academy of Medicine was held on September 15th at St. Mary's Hospital, Green Bay. Dr. R. M. Carter, Green Bay, read a paper on "The Estimation of Permanent Functional Disability Following Fractures." Discussion was opened by Dr. H. Hendricksen and Dr. Arthur McCarey.

The October meeting of the Academy was held at the Bellin Memorial Hospital, Green Bay, on the 12th of the month. Dr. R. C. Cantwell, Shawano, presented a paper on "The Diagnosis and Treatment of Gastric and Duodenal Ulcers." The subject was formally discussed by Drs. W. H. Bartran and O. W. Saunders. *O. A. S.*

MILWAUKEE ACADEMY

At a meeting of the Milwaukee Academy of Medicine on October 11th, Dr. N. Enzer, Milwaukee, presented a case of "Congenital Heart," with specimen; Dr. T. L. Squier, Milwaukee, reported on "Experimental Hypotension in Rabbits," and Dr. C. C. Schneider, Milwaukee, spoke on "Stenosing Fibrous Tendovaginitis over the Radial Styloid." *D. E. W. W.*

MILWAUKEE OTO-OPHTHALMIC

The regular monthly meeting of the Milwaukee Oto-Ophthalmic Society was held Tuesday evening, October 18th, at the University Club. This was the first meeting following the summer recess and an unusually attractive program had been arranged. Following the six-thirty dinner Dr. Herbert G. Schmidt spoke on "The Clinical Significance of Spontaneous Nystagmus"; Dr. B. J. Birk and Dr. W. E. Grove presented a case report on "Cerebellar Lesion," and Dr. Charles J. Coffey discussed a case of "Cerebellar Abscess." *E. R. R.*

UNIVERSITY OF WISCONSIN

The University of Wisconsin Medical Society held its first meeting of the year in the Science Hall, Madison, on September 26th. Dr. William P. Murphy of the Harvard Medical School, Boston, reported the results of his work with Dr. Minot on "The Dietetic Treatment of Pernicious Anemia." Most remarkable improvement, in clinical symptoms and in the blood picture, was observed in nearly all of about 125 unselected cases treated with special diets containing liver or liver substitutes. Whether this improvement is permanent, or only a remission which must be maintained by continuation of the diet, is as yet undetermined. Evidence was also brought forth indicating that the liver has an action similar to insulin in reduction of blood sugar.

At the business meeting the following officers were elected for the ensuing year: President, Dr. E. R. Schmidt, professor of surgery; Vice President, Dr. F. D. Geist, anatomy department; Secretary and Treasurer, Dr. H. W. Cromwell, department of bacteriology. *H. W. C.*

NEWS ITEMS AND PERSONALS

Dr. H. C. Werner, practicing physician in Fond du Lac for twenty years with the exception of seven years as superintendent of the Southern Wisconsin Colony and Training School at Union Grove, has accepted the appointment as superintendent of the Wisconsin Memorial Hospital at Mendota. He succeeds Dr. C. C. Atherton, who will return to his old position as superintendent of the Southern Wisconsin Colony and Training School at Union Grove.

—△—

Dr. A. C. Radloff, Plymouth, who has been seriously ill for a period of about six months, is reported to be well on the road to recovery. He will resume his practice again in the near future.

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Dr. T. A. Hagerup, Dodgeville, and Dr. H. H. Morton, of Cobb, returned in September from a two months' trip abroad. They visited Norway, Sweden, France, Germany and pursued a post graduate course in surgery at Vienna, Austria.

—△—

Dr. C. E. Garner, Livingston, has opened offices in the Parry Block, Dodgeville.

—△—

Dr. Arnold Jackson, Madison, was a guest of the Colorado State Medical Society at Glenwood Springs, Colorado, where he gave an address on the "Diagnosis and Surgical Treatment of Goiter" at the annual meeting of the society. He also read a paper before the Putnam County Medical Society at Union City, Indiana, during September.

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Dr. Harry V. Gibson, formerly of Madison, has become associated with the Schiek Clinic at Rhinelander. Dr. Gibson is a graduate of the Washington University School of Medicine in 1924 and for the past few years has been with the Wisconsin General Hospital as teacher in the medical school and laboratory and as associate clinician for the psychiatric service.

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Dr. F. S. Tuffley, who has been in practice at Boscobel for some years, is now established at Baraboo, having opened offices in the First National Bank building.

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Dr. S. E. Gavin, of Fond du Lac, addressed the annual convention of the Wisconsin Chiropodists' Association held at the Hotel Retlaw on October 2nd and 3rd. He spoke on "Skin Diseases."

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Wisconsin was well represented at the Eleventh Annual Convention of the American Occupational Therapy Association held in Minneapolis, October 10th, 11th and 12th. Dr. Glenford L. Bellis, superintendent of Muirdale Sanatorium, Wauwatosa, spoke on the medical, general and social considerations of occupational therapy.

The work being done with convalescents at Tomahawk Lake Camp, Tomahawk Lake, Wisconsin, in preparing them for industrial activity on their final discharge as arrested tuberculous cases, was the subject of an address by Dr. B. E. Hedding of the Wisconsin Anti-Tuberculosis

Association, Milwaukee. Other speakers on the program were: Mrs. Carl Henry Davis, Milwaukee, member of the board of managers of the national association; Miss Irene Grant, chief occupational therapist at Muirdale Sanatorium; Miss Hilda Goodman, director, Junior League Workshop, Milwaukee; Miss Margaret M. Lison, executive secretary, Wisconsin Association for the Disabled; Miss Elsa Dudenhoefer, director, occupational therapy, Milwaukee Children's Hospital, and Mrs. B. C. Lafferty, president of the Wisconsin Occupational Therapy Association.

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Dr. C. T. Droege is Watertown's latest acquisition to the medical profession. He has established offices in the Woolworth Building on Main Street. The doctor is a graduate of Marquette University Medical School and has been at St. Mary's Hospital, Milwaukee, for the past four years.

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Dr. Malcolm M. Hipke has returned from Detroit, where he served as resident physician at the Harper Hospital the past year. Dr. Hipke, who is a graduate of the University of Michigan Medical School, will continue his practice in Milwaukee.

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Three physicians were speakers on a "Public Health" program sponsored by the Mineral Point Woman's Club recently. Dr. H. D. Ludden, Mineral Point, gave an interesting talk on "The Decrease in Infant Mortality." Dr. L. S. Graves, city health officer, spoke on local health conditions, and Dr. F. W. Henika, Madison, deputy state health officer, addressed the club on "Diphtheria."

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The Grandview Hospital School of Nursing, La Crosse, graduated eighteen nurses at a recent commencement function. Dr. W. A. Henke was toastmaster at the banquet and Dr. B. W. Mast and Dr. R. L. Eagan spoke briefly on behalf of the hospital staff.

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Dr. F. E. Brinckerhoff, who has been associated with the Beloit Clinic for the past three years, left Beloit recently for Philadelphia, where he will take an extended course in surgery at the Post Graduate Medical School of the University of Pennsylvania. He expects to be absent from the city for about two years.

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At a convocation conducted in Detroit, Michigan, during October in connection with the Seventeenth Annual Clinical Congress, Dr. F. E. Butler, Menomonie, received the degree of Fellow in the American College of Surgeons.

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Dr. Edwin Thorsness has become associated with Dr. G. A. Grinde and Dr. S. O. Lund in the practice of medicine at Cumberland. After graduating from the Marquette University School of Medicine, he served his interneship at St. Francis Hospital, La Crosse, and spent three months in the Gundersen Clinic of that city.

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Dr. Fred Prehn, who has recently completed an interneship at St. Luke's Hospital, Chicago, has opened an office for general practice at 220½ Third St., Wausau. Dr. Prehn is a graduate of the University of Illinois College of Medicine, Chicago.

—△—

Dr. D. R. Aves, formerly of Birnamwood, has established his practice in the Heckman Building at Bear Creek.

—△—

Dr. G. L. Bellis, superintendent of Muirdale Sanatorium, presided recently at a section meeting on tuberculosis held for the first time in connection with a convention of the American Hospital Association, Minneapolis. Dr. J. W. Coon, Stevens Point, led a discussion on "The General Hospital and Tuberculosis."

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Dr. Frank Birnbaum, a recent graduate of Marquette University Medical School, has purchased the practice of Dr. P. J. Taugher at Marathon.

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Dr. J. A. Hernandez, formerly of Green Bay, is now practicing at Stratford.

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Dr. Q. H. Danforth, Omro, has become associated with Dr. H. W. Morgenroth in the practice of eye, ear, nose and throat work at the Oshkosh Clinic.

—△—

Dr. John McEachern, Milwaukee, has accepted an appointment to the staff of the Faculty of Medicine, University of Manitoba, Winnipeg.

Dr. R. E. Buckley has sold his practice at Redgranite to Dr. H. F. Beglinger, of Oshkosh, and has opened offices at 626 High Street Racine.

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Dr. Sylvia G. Stuessy, Madison, has recovered from an illness of several weeks and has resumed her work with the Bureau of Child Welfare.

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Dr. Charlotte J. Calvert, who has been on leave of absence from the Bureau of Child Welfare since April, has returned from a trip abroad. Dr. Calvert visited the Hospital for Sick Children in London, the Infant Welfare Clinics in Paris, Dr. Pollier's Hospital for Tuberculous Children in Leysin, Switzerland, and spent the summer in study at the Pirquet Children's Clinic of the University of Vienna, Austria.

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Dr. H. B. Norviel, formerly of Tigerton, has established his practice at Phillips and will occupy the offices vacated recently by Dr. L. E. Odell. Dr. Norviel is a graduate of the University of Illinois School of Medicine.

MARRIAGES

Dr. Robert J. Hudson, Prairie du Sac, to Miss Agnes Leonette Jenks, La Crosse, on October 1st.

Dr. John W. Monsted, Jr., New London, to Miss Kathleen Nero, Bottineau, N. D., at Hartland on September 22nd.

Dr. Benjamin Gasul, Kenosha, to Miss Lala May Rosenzweig, Chicago, on October 9th at Vienna, Austria.

DEATHS

Dr. Charles A. Faber, Milwaukee, died Monday, October 3rd, at his residence following an illness of several weeks. Dr. Faber was a graduate of Rush Medical College, Chicago, in 1897 and was licensed in the state of Wisconsin shortly thereafter. He has been in continuous practice in Milwaukee since that time.

Dr. Faber was a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his widow and a son.

Dr. Anna Brown Corr, Juneau, died at her home on October 7th after a lingering illness. Dr. Corr was born in 1863 and was a graduate of Northwestern University Woman's Medical School in 1890. She was prominently known throughout Dodge County, having practiced in that vicinity for many years.

The deceased was formerly a member of the Dodge County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. She is survived by a daughter and three sons, one being Dr. Phillip Corr of Madison.

Dr. Sherman Morris Kyes, Oshkosh, died Monday, October 10th, at St. Joseph's Hospital, Marshfield. Death was caused by a stroke of apoplexy sustained Sunday morning while Dr. Kyes was riding on a train between Stevens Point and Marshfield. Dr. Kyes was born at Gananoque, Canada, on May 25, 1866, and was graduated from the University of Illinois School of Medicine, Chicago, in 1902. The physician served his interneship at the Westside Hospital, Chicago, and practiced at Centralia, Weyauwega and Owen before coming to Oshkosh in 1924.

Dr. Kyes was a member of the Winnebago County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He is survived by his wife, a son and two daughters.

SOCIETY RECORDS

New Members

Wall, M. H., Superior.
Kreuzer, T. C., Superior.
Longstreth, C. L., Rice Lake.
Winn, H. N., Madison.
Masten, M. G., Madison.
Berg, W. R., Gillett.
Kimberlin, H. C., Ashland.
Backe, Irma A., Madison.
Romberg, H. A., Oshkosh.
Campbell, E. J., Oshkosh.
Ford, A. McD., Roberts.
Cannon, Clair R., Ellsworth.

Changes in Address

Werner, H. C., Fond du Lac, to Mendota.
Esser, O. J., Madison, to New Ulm, Minn.
Bossard, M., Spring Green, to West Bend.
Slaney, A. F., Stockbridge, to 150 Second St., Kaukauna.
Herman, A. H., Woodruff, to Reedsville.
Wiger, H. C., Barron, to Rice Lake.
Festerling, E. G., Reedsville, to 1770 Pt. Washington Ave., Milwaukee.
McEachern, J. M., Milwaukee, to 7 Roslyn Road, Winnipeg, Can.
Aves, D. R., Birnamwood, to Bear Creek.
Danforth, Q. H., Omro, to 19 Jefferson Ave., Oshkosh.
Norviel, H. B., Tigerton, to Phillips.
Jackey, F. D., Thorp, to 9442 S. Laflin St., Chicago.
Stark, R. M., Milwaukee, to 912 Commercial St., Appleton.
Buckley, W. E., Redgranite, to 626 High St., Racine.

CORRESPONDENCE

"MILE STONE"

Sept. 28, 1927.

J. G. Crownhart,
Milwaukee, Wis.
Dear Mr. Crownhart:

Yours, twenty-seventh instant, is before me and I note your suggestion. Now, dear Crownhart, we feel that the honor conferred by the State Medical Society of Wisconsin is a greater tribute than we ever expected. We consider this the "Last Mile Stone" in our lives, therefore we could not for a moment consider "A Rebate" of our expense to the meeting at Eau Claire. I assure you we shall endeavor to attend coming meetings with as much pleasure as in the past.

Again thanking you and the Society, we remain,
Cordially and sincerely yours,
Dr. and Mrs. L. H. Pelton.

Maintenance of the 15 county sanatoria and of the 7,400 chronic insane in 36 county asylums cost a total of $1,750,574 during the fiscal year ending June 30 and besides this counties will pay $563,385 for the support of their residents in state institutions, the state board of control announced in October.

Of the $498,422 that it cost to run the sanatoria for a year the state's share amounted to $347,904 while the counties' share was $150,517. Had the counties operating the sanatoria been charged for their own county patients the total amount expended would be about $800,000. Under the new law the state pays $7 maintenance charge per week while the difference is paid by the counties. Rates at the institutions vary from $14 to $23 a week. The new system of distributing costs will go into effect for the year ended in June, the board announced.

The expense of $1,252,152.51 for the care of the 7,400 chronic insane cases was divided with $909,369 paid by the state and $342,782 by the counties. Had the counties operating the asylums been charged for the care of their own patients the sum would be nearly $1,900,000. Ten years

ago the amount for this work amounted to $170,305 with the population at the institutions at that time 6,100. Included in the 7,400 cases are 400 private cases where maintenance is paid by relatives.

Figures presented by the board of control show that counties will pay $178,849 for the care of their insane in the two state hospitals for the insane and the hospital for the criminal insane.

* * *

A more accurate system of awarding compensation for eye injuries under the workmen's compensation act is being worked out by the state industrial commission along lines recommended by the American Medical Association and the new rules that will apply for eye injury cases will be announced soon.

The industrial commission is called on annually to act in compensation cases for eye injuries to the extent of several hundred times a year. Under the present system, Wisconsin, like many other states, has definite automatic compensation rates for sight impairment, but under the system now being worked out it will be possible to grant compensation on the basis of actual handicap by accurate tests. The new system is being worked out in cooperation with noted eye experts. Wisconsin expects to be the first state to adopt the plan.

* * *

A telephone company can drop its rates as low as it wants to, although such reduction in rates may be for the purpose of driving a competitor out of business and bring a return far below the cost of the service given, according to a ruling by the railroad commission. The ruling came on a case from Lancaster, where a Farmers' Telephone company and the Wisconsin Telephone Company are in stiff competition. The Wisconsin Telephone Company dropped its rates to $1 a month and the Farmers' Company claimed that this was unfair competition and asked the railroad commission to set a higher rate for both companies so that they would be forced to compete on a paying basis. The railroad commission refused with the declaration that it has interpreted its authority merely to permit higher rates but without the power to force a company to charge more. As a result the Lancaster price war will continue.

* * *

L. B. Nagler, formerly private secretary to Gov. Fred R. Zimmerman, has been selected by the newly created state conservation commission as a director of conservation. He succeeds Elmer S. Hall, Green Bay, who held the post of conservation director for five years.

James H. Vint, Union Grove, has been named Commissioner of Markets. He succeeds Edward Nordman, whose term of office had expired.

* * *

Members of the legislature who have voted to create a new department of government or to increase the salary of any office cannot be appointed or elected to the new office or to the post where there has been a salary increase, during their term of office. This is the opinion of Attorney General John S. Reynolds. The opinion bars Milwaukee members of the legislature from being candidates for the county board because the legislature increased the salary of Milwaukee county board members at the last session. By the same constitutional provision all members of the present legislature will be barred from becoming candidates for governor next fall, because the legislature increased the salary of governor from $5,000 to $7,500 a year, beginning with the next term. Few, if any, members of the legislature knew of this constitutional provision when they cast their votes.

* * *

The University of Wisconsin has the largest attendance in the history of the institution this year. Over 9,000 students are registered in the regular courses. This number will be greatly augmented later by the enrollment of students for the dairy course and the short courses in agriculture.

* * *

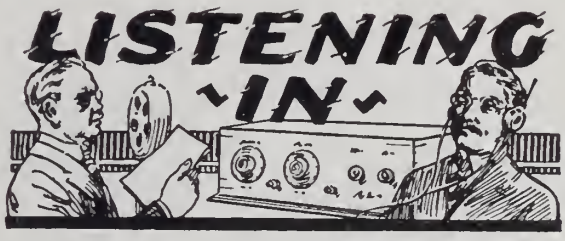
The new medical building at the University will be ready for use next September. The walls of the building are already up and work on the interior will start in December. The building is adjacent to the Wisconsin General Hospital.

* * *

E. G. Doudna, Madison, has been selected by the state board of normal school regents as secretary, succeeding William Kittle, who held the post for twenty-five years. Mr. Doudna expects to resume his duties in December. For several years Mr. Doudna has been secretary of the Wisconsin Teachers' Association.

* * *

County institutions had 9,090 and state institutions had 6,509 inmates on October 1, the board of control announced. This is an increase since last October 1 of 317 in the state institutions and of 269 in the county institutions.



An Essential Reference

Members will be interested to know that hardly a day passes at the headquarters of their State Society but what some application is made requesting information as to whether a given physician is a member of his county and state societies. One of the most frequent users of the office is the United States Civil Service Commission; another is an insurance company that will not insure a physician against malpractice unless he is a Society member; others include industrial concerns, state service, etc.

When the physician named is not a member the investigation files maintained by the Society often disclose information indicating why the physician could not become a member of his society. Where such files disclose no information the answer is always made, "Dr. Blank is not a member of his county medical society, nor his state medical society nor the American Medical Association. We regret our inability, therefore, to afford you further information."

Missed Opportunities

"How often does the family physician return to the home where some months ago he assisted at birth and say, 'Now is the time to have the baby vaccinated'," said a physician from Chicago, a visitor at Society headquarters.

"Likewise, how often does the family physician follow up to see that diphtheria toxin-antitoxin is given; and let me add, how often does he suggest an examination about the time the child is ready to enter school?

"This is not work for the health department nor free clinics but something that every parent owes the child and in most instances is capable and willing to pay for, once it is brought to the parents' attention. We physicians need to be jogged up about this every once in a while."

Malpractice

That physicians might well give more attention to the prevention of malpractice suits rather than to their defense was the belief of the medical-legal expert and visitor.

"I hope the medical defense committee in Wisconsin," said the visitor, "that has been doing such splendid work along defense lines, will carry these efforts into the fields of prevention. How often are lawyers sued for malpractice? The question answers itself.

"Let us now spend some time and money in taking up each malpractice case to trace just what started the suit and then have that information published for the benefit of all members."

Possible Hardship

That annual re-registration of physicians has dangers as well as benefits was the suggestion of the doctor from Milwaukee County.

"It so happens," he said, "that upon my graduation from Rush I was licensed in Illinois and subsequently I went to Rochester so that I obtained my license in Minnesota. Then I returned to Wisconsin and while I never expect to leave the state, I would not like to see my Illinois and Minnesota licenses lapse. Now Minnesota has a re-registration fee of $5.00 a year and I am just thinking if Illinois and Wisconsin and all other states would enact like laws there would be a good many of us who would feel it financially."

Letting George Do It

A warning to the secretary not to so devote his time to individual cases as to miss the opportunity of serving the whole membership was the thought of a visiting secretary.

"The greatest service of the state organization is not to do a thing for Dr. Jones or Dr. Smith that they can easily do for themselves but to do the things that will affect a large group and which the individuals that compose that group could not readily do for themselves.

"I do not mean to discourage your offers of service but to suggest that you must guard the future extension carefully that you do not spend your time in working out small individual problems and thus miss the greater opportunity to think about and work upon the larger problems."

Proceedings, House of Delegates, 1927, The State Medical Society of Wisconsin

TUESDAY EVENING SESSION
September 20, 1927

The meeting of the House of Delegates of the Eighty-Sixth Annual Meeting of the State Medical Society of Wisconsin convened in the Hotel Eau Claire, Eau Claire, Wisconsin, at seven forty-five p. m., Dr. K. W. Doege, of Marshfield, Wisconsin, the Speaker, presiding.

SPEAKER DOEGE: Gentlemen, you have been sent by your county to represent your county in this organization. There is always a certain amount of important business to be done in a big organization like the Wisconsin State Medical Society that can best be done in a small body. For that purpose, they have selected you to represent their interests and to do whatever is necessary in this organization. The object of your being here is not only to select officers and hear the report of the committees and so forth, but another object is to solve the problems of much wider scope.

In every great organization like this there are always questions involving the public as well as involving the welfare of the physician himself. There are always problems to be solved, and serious-minded men have thought over these problems on various occasions, and often representing them to the delegates in the form of resolutions. These resolutions, before they are put before the House of Delegates, are generally talked over. Before they are put before the society as a whole they are generally scrutinized by the House of Delegates.

Tonight we will probably have similar things to discuss. It is not necessary for me to address you any further as far as your duties are concerned. I want you to be lenient with me, for it is the first time I am acting as Speaker for the House of Delegates. I shall try to make as few mistakes as possible, and shall lean heavily on our Secretary, who will help me out in a good many instances, I am sure.

I will now announce the committees which have been appointed.

The Committee on Credentials consists of Dr. W. F. O'Connor, of Ladysmith, Dr. H. M. Coon, of Stevens Point, Dr. F. E. Turgasen, of Manitowoc.

The Committee on Resolutions consists of Dr. H. M. Stang, of Eau Claire, Dr. S. J. Seeger, Milwaukee, Dr. E. A. Riley, of Park Falls.

The Committee on Officers' Reports consists of Dr. V. F. Marshall, of Appleton, Dr. C. C. Vogel, of Elroy, Dr. W. H. Bayer, of Merrill.

The Committee on Committees' Reports consists of Dr. A. E. Bachhuber, of Mayville, Dr. W. E. Bannen, of La Crosse, Dr. J. M. Freeman, of Wausau.

We will now listen to the report of Dr. W. F. O'Connor, of Ladysmith, chairman of the Credentials Committee.

DR. O'CONNOR: Mr. Speaker, Marathon County,

through its secretary, has sent us instructions that the regular delegate and alternate are both unable to be present this evening. They have, therefore, appointed Dr. S. M. B. Smith, of Wausau, to act in their stead. Also the counties of Ashland, Bayfield and Iron have appointed Dr. H. G. Mertens, of Bayfield, to act as a regular delegate at this meeting.

SPEAKER DOEGE: I will now entertain a motion that the report of the Committee on Credentials and the report of the registered delegates constitute the roll of this house.

DR. OSCAR LOTZ (Milwaukee): I so move.

The motion was seconded by Dr. A. J. Gates, of Tigerton, and carried.

SPEAKER DOEGE: I will now call for the reports of standing committees and reports of officers. These reports have, for the most part, been printed in the September issue of the Journal, and you probably have read them. However, I will call upon each chairman for any additional statement he may make to the House. First, the Committee on Public Policy. Dr. Bock is not here. This report will not be read, but will be referred to the Reference Committee on Reports of Standing Committees. Second, the Editorial Board.

DR. LOTZ: Nothing more to add.

SPEAKER DOEGE: I will entertain a motion for the acceptance of the report as you have read it in the Journal.

DR. W. H. BAYER (Merrill): I move the report be accepted as printed in the Journal.

The motion was seconded by Dr. Arthur Rogers, Oconomowoc, and Dr. A. J. McDowell, of Soldiers Grove, and carried.

SPEAKER DOEGE: The report of the Committee on Medical Defense.

DR. J. P. McMAHON (Milwaukee): Dr. Patek said he wouldn't be here.

SPEAKER DOEGE: I will entertain a motion to accept the report as printed in the last issue of the Journal.

DR. ROGERS: I so move.

The motion was seconded by Dr. J. F. Mauermann, of Monroe, and carried.

SPEAKER DOEGE: The report of the Committee on Medical Education, Dr. Bardeen. This report is also ready for acceptance by the House. I will entertain such a motion.

DR. JOSEPH SMITH (Wausau): I move that the report be accepted.

The motion was seconded by Dr. O'Connor of Ladysmith and carried.

SPEAKER DOEGE: The report of the Committee on Health and Public Instruction by Dr. Stovall. This report is referred to the Reference Committee on Reports of Standing Committees.

The Committee on Necrology. Any corrections or additions to this report? If not, I will entertain a motion for its acceptance.

DR. ROGERS (Oconomowoc): I move, Mr. Speaker, that the report be accepted.

The motion was seconded by Dr. J. O. Dieterle, of Milwaukee, and carried.

SPEAKER DOEGE: The report of the Committee on Hospitals, Dr. R. C. Buerki. This report is also ready for acceptance by the House. I will entertain a motion for its acceptance.

DR. J. F. MAUERMANN (Monroe): I move that the report be accepted.

The motion was seconded by Dr. Gates, of Tigerton, and carried.

SPEAKER DOEGE: Now we are ready to receive the reports of delegates to the various county medical societies. Dr. Nott, of Racine, is unavoidably detained and cannot give his report. I will call upon Dr. Stang to give his report as to the Minnesota meeting.

DR. H. M. STANG (Eau Claire): I had a few typewritten notes in regard to the meeting, but unfortunately they have been mislaid. So I will give you a little extemporaneous report of what I learned at the meeting at Minnesota. The idea of sending the delegate was to see if there was anything that they had up there that could be of benefit to us here. I can assure you that I feel that the delegates being sent to these other states is worth while. I was very royally entertained. They were happy to see me, and I was extended an invitation to sit in at all their meetings, even as far as the council meetings. The program was a very interesting program, I believe. It was held at the New Duluth Hotel and was composed of various symposia with papers varied in length of time. Some only took ten minutes, some fifteen, some thirty. There were a considerably larger number of speakers than we have had on our programs.

The procedure of the House of Delegates, I believe, is practically the same as we have in this state. However, I feel that our meetings have proceeded with a little more dispatch and not quite so slow as the meeting at Duluth. One outstanding feature predominated the whole meeting, and that was they were all enthusiastic about the passage of the Basic Science law, which they patterned after this state. The fact that Wisconsin was the first to pass it was mentioned many times. I do not believe the law is quite as good as ours, but it is very practical and a very sound law. One thing that was learned was that if you are going to get anything through the legislature you have to work for it, and they certainly worked for it. There was one man, Dr. H. M. Johnson, who is from a small town, who put this law through, and it was with a great deal of effort and a great deal of assistance. I know many men stated that at times there were some assemblymen or senators who were faltering and at two o'clock in the morning they would get a telephone message from Dr. Johnson that they had to be in St. Paul at a certain time without fail. He was very enthusiastic, and has given up practically a whole year of practice besides a great deal of personal expense, without hardly any expense to the state society. There was a lesson to be learned, in that if we are going to secure anything through the state legislature when those telegrams and those special delivery letters come to us from George or Dr. Harper, or some one else, we have to act and act fast, and do it regardless of whether we think we are busy at that time.

There was also brought up from the floor criticism in regard to the compensation law. At the present time they felt the insurance companies were taking the patient out

of the hands of men in general practice. They demanded the doctors representing the insurance companies should take the case, and they were wondering if there were not some way whereby this could be worked out satisfactorily in case the patient desired his own doctor. In that case the patient, they believed, had a right to have that doctor, and that doctor should not lose the patient as is very often done.

There was a report from Dr. Law in regard to the A. M. A. delegates. His greatest message was this: that the same delegate should go back each year to the national meeting, because it took so long for a man to learn the workings of the A. M. A. He should be there year after year, so that he knows the ropes and is of value; until he has been there several years he is not of any value, which I am sure Dr. Sleyster will bear out.

The various committees gave their reports, as they are doing here. There was also a very interesting talk by Dr. Ferguson, of Chicago, in regard to lay education. They started out in Illinois with practically no funds and appealed to the public, and now they have a large fund given by lay people, which is used to educate the public in regard to health problems. This is accomplished through press bureaus, speakers' bureaus, the extension bureau, and a lay educational committee which has been in action now for four years. As far as the lay education in Minnesota is concerned, I think they are behind Wisconsin. They have not been doing a great deal, and Dr. Earl, who is in charge, admitted it has been practically the last two years that anything has been done, and that there is a great deal that must be accomplished, which they are going to attempt in the next few years.

One thing they stressed especially was this: in regard to the periodic health education, start on the children now and educate them as children, so when they grow up, in a few years to come, they will be educated to this health progress.

The women's auxiliary, a very active organization in the state of Minnesota, is doing interesting work. They have their own officers. They have their own meetings, and probably it is something we can work out in this state. I believe it would be of benefit to the State Society as a whole.

I can only express my appreciation for being sent as a delegate to Minnesota, and I hope that the other delegates in the future enjoy the trip as much as I enjoyed it this year. The good feeling that resulted from it was worth while. Immediately the state of Minnesota voted to send four delegates to its neighboring states, the two Dakotas, Iowa, and Wisconsin.

SPEAKER DOEGE: I am sorry that Dr. Nott is not able to be here to present his report from Illinois.

I will now call upon the chairman of the council. Dr. Evans.

DR. EDWARD EVANS (La Crosse): Mr. Speaker, I have very, very little to say in connection with this report. You will find it printed on page 485 of the September Journal. I would just like to emphasize one or two things. I have been on the council now for a long time, and I want to say to you there are a bunch of men representing you on the council whom I think would be very hard to equal. These men give their time without any expense to the State Medical Society, and I know they are doing good work. When the change in the Constitution comes up tonight, if you gentlemen vote to change the Constitution, I hope that in the district meetings where the council will then be elected, you will use good judgment and care in selecting the sort of men you send to take the place of those men who are now on the council.

At a meeting like this, I think it is a good thing now and then if we get away from material things in our profession and perhaps turn a little to the more sentimental things. Tonight I see in the audience—and I would beg you, Mr. Speaker, to appoint a committee to bring him to the platform—one of our old members, Dr. Pelton of Waupaca.

SPEAKER DOEGE: I shall be glad to appoint a committee of three, Dr. Rogers, Dr. Redelings, and Dr. Sleyster, to escort Dr. Pelton to the platform. (Dr. L. H. Pelton, of Waupaca, was escorted to the platform.)

DR. EVANS: While Dr. Pelton is coming up, let me say to you that we honor ourselves in honoring Dr. Pelton. At the council meeting today he was voted an honorary member of the State Medical Society. I know of no man in the state of Wisconsin so deserving of that honor. Dr. Pelton graduated in '73, a long time ago. He came to the state of Wisconsin in '74, and ever since then has been an active, honored member of the medical profession and an outstanding citizen in whatever community he lived. He served as president of this society about twenty years ago. He has always been distinguished for his splendid citizenship, his interest in schools and education, in medical matters, and it is a mighty great pleasure to me to welcome my old friend, Dr. Pelton, here tonight. (The members arose and applauded.)

DR. L. H. PELTON (Waupaca): Mr. President and Members of the House of Delegates: I assure you this is one of my great pleasures. I feel that I am hardly deserving of such an honor, and were I to be asked at this moment what I most desired I would reply more light that I might be able to see the countenances of these men who have been so loyal, far more so and far more laboring in this society than I have been. I can only say this in response: that had I to live my life over again, with the experience I have had, I know of no calling that I would sooner choose than that of the practice of medicine. There is no calling where a man is called upon to witness the suffering and the happiness and the dejected countenance of not only his intimate friends but friends of his acquaintances, and to be able to alleviate that suffering is one of the greatest things that we can accomplish.

Gentlemen, I don't feel qualified to respond to this, I will say, extreme honor which has been conferred upon me here tonight by this House of Delegates. I can only say this: that I wish each and every one of you may retain your mental elasticity, your sight, and your physical elasticity to go along with it, that you may reach the century mark. I have often said I would be glad if I could retain those to see where we would land; the last fifty years in the practice of medicine and surgery, which has been one of the greatest periods in the history of medicine, has no period to equal it. To think of going

into parts of the body, where when I graduated, it was the extreme rarity that they would open up any of those cavities.

I know you are busy and have a great deal on your minds and a great work before you. I only wish that I could live with you, and arrive at the century mark. And if I cannot see, I have retained in a measure that attentive ear that I can recognize many of my friends by their cordial salutation. The sense of touch is with me yet, and I hope that I shall be able to touch and grasp your hands for many years to come. I thank you. (Applause.)

SPEAKER DOEGE: I want to assure Dr. Pelton that it is not only his wish but our wish that he may be with us for many years yet, that he may enjoy the further progress that medicine may make along its chosen lines. We have with us besides Dr. Pelton today some one who has been quite instrumental in bringing Dr. Pelton to that point of success in his life's work that he has attained. It is Mrs. Pelton, his wife. I would like to ask Mrs. Pelton to stand up and face the audience. (The members arose to pay tribute to Mrs. Pelton.)

Now we will listen to the report of the delegates to the American Medical Association. The report of the action of the A. M. A. was contained in the July issue of the Journal. I will call on Dr. Joseph Smith for an additional report at this time.

DR. JOSEPH SMITH (Wausau): The meeting of the House of Delegates of the American Medical Association held at Washington last April was characterized by the usual amount of business. A great deal of that was more or less routine, and perhaps much of it was not of particular interest to us here. Two or three things came up which I think interested us all. One of them was the alcohol question, which comes up before every meeting of the House of Delegates. It was pointed out that Congress has recently passed a law limiting the amount of alcoholic liquor a physician may prescribe to any one patient, I think, at a pint in ten days. If I am in error, I hope you will correct me. That is my impression. It was not so much the idea of limiting the patient to a pint of whisky in ten days that concerned the delegates, but the precedent which this establishes. If Congress may elect or decide to dictate to the medical profession how much alcohol they may give in a week to a patient, it is only one step further to say how much strychnine or potassium iodid or any other drug they may give in the same length of time. And the sense of feeling in the House of Delegates was very strongly against this as an encroachment upon the rights of the medical profession. The sentiment was that the doctor is the one who should be the judge as to the amount of any medicinal agent the patient should receive, and he alone, and that he should be responsible to no other authority, legislative or otherwise, for the administration of any given amount of any medicinal agent.

The matter of the value of alcohol as a therapeutic agent was referred to the Scientific Assembly with the request that they determine, if possible, the value of alcohol and report at a later meeting of the House of Delegates.

There were two other measures of a similar character. You perhaps are aware that the Narcotic Division of the Bureau of Internal Revenue has a great mass of decisions that have been made that have never been a law in the sense that they have never been enacted by any legislative body. Yet these decisions have been made by the Commissioner under the heading of rulings, many of which we are not aware of in any sense and have no means of being aware of their existence or their import. We find ourselves every now and then as physicians running into certain rulings or regulations that are imposed by this autocrat, which is called the Commissioner of Internal Revenue. This applies not only to the Narcotic Division, but applies equally to the revenue derived from taxation. I have no doubt that many of you, in making out your income tax, have run into certain rules that the czar of internal revenue department has made of which you are not aware, and regarding which you were never given an opportunity to be heard. The Bureau of Legal Medicine of the A. M. A. is asking that in all matters of proposed rulings that have some effect upon the administration of medicine and drugs the medical profession should be heard; that we should have the right to appear before the Commissioner of Internal Revenue and be heard as to our feeling in regard to the value of any proposed ruling. The justice and simple fairness of such a law must be, I think, apparent to all, and it is hoped that the action taken by the House of Delegates will be followed up until some check can be placed upon these rulings that are made from time to time without our knowledge and without our consent. I think these are the two outstanding things that impressed me in the work of the House of Delegates.

SPEAKER DOEGE: This report will be referred to the Reference Committee on Reports of Officers.

We will now listen to the report of the Treasurer, Dr. Rock Sleyster.

DR. ROCK SLEYSTER (Wauwatosa): The report has been published in the Journal. I shall be glad to report a few changes during the month:

WISCONSIN STATE MEDICAL SOCIETY—SUPPLEMENTARY TREASURER'S REPORT

September 19, 1927

	General Fund	Medical Defense Fund	Balance
Balance, as previous report.....			$11,326.10
RECEIPTS:			
Aug. 3—J. G. Crownhart (petty cash)	100.00		
Sep. 6—J. G. Crownhart, Sec'y.....	190.70	22.00	
Sep. 12—Cameron Surgical Co.....	100.00		
Sep. 17—H. G. Fischer & Co.....	23.33		
Sep. 17—H. G. Fischer & Co.....	23.34		
Sep. 17—Mellin's Food Co.....	50.00		
Sep. 17—Horlick's Malted Milk.....	40.00		549.37
	527.37	22.00	
			11,875.47
DISBURSEMENTS:			
Aug. 9—Milwaukee Acad. of Medicine	48.00		
Aug. 15—1st Wisconsin Natl. Bank..	2,000.00		
Aug. 29—Lines, Spooner & Quarles..		983.00	
Sep. 2—Lines, Spooner & Quarles....		35.00	
Sep. 2—Fred L. Holmes.....	175.00		
Sep. 2—J. G. Crownhart.....	400.00		
Sep. 2—Florence Ripley.....	104.00		
Sep. 2—Astrid Jurgens.....	120.00		
Sep. 2—J. G. Crownhart, Sec'y.....	181.73		

Attendance, House of Delegates, Eau Claire, 1927

Society	*Delegate*	1	2	3
Ashland-B-I	J. M. Dodd, Ashland	x	x	a
	H. G. Mertens, Bayfield*	x	x	a
Barron-P-W-S-B	D. L. Dawson, Rice Lake	x	x	a
Brown-Kewaunee	P. R. Minahan, Green Bay	x	x	a
Chippewa	W. C. Henske, Chippewa Falls	x	x	x
Clark	S. G. Schwarz, Marshfield	x	x	x
Crawford	A. J. McDowell, Soldiers Grove	x	x	x
Dane	W. T. Lindsay, Madison	x	a	x
Douglas	T. J. O'Leary, Superior	x	x	a
Eau Claire and Associated Counties	O. J. Blosmo, Menomonie	x	x	a
Fond du Lac	S. E. Gavin, Fond du Lac	x	x	x
Grant	J. C. Betz, Boscobel	x	x	x
Green	J. F. Mauermann, Monroe	x	x	x
Jefferson	H. O. Caswell, Ft. Atkinson	x	x	a
Juneau	C. C. Vogel, Elroy	x	x	a
La Crosse	W. E. Bannen, La Crosse	x	x	a
	E. E. Gallagher, La Crosse*	x	a	a
Langlade	J. C. Wright, Antigo	a	x	a
Lincoln	W. H. Bayer, Merrill	x	x	x
Manitowoc	F. E. Turgasen, Manitowoc	a	x	x
Marathon	S. M. B. Smith, Wausau	x	x	x
Marinette-Florence	G. R. Duer, Marinette	x	x	x
Milwaukee	R. W. Blumenthal, Milwaukee	x	x	x
	C. J. Coffey, Milwaukee*	x	x	a
	J. O. Dieterle, Milwaukee	x	x	a
	S. G. Higgins, Milwaukee	x	x	x
	W. M. Kearns, Milwaukee	x	x	a
	B. Krueger, Cudahy	x	x	x
	Oscar Lotz, Milwaukee	x	x	x
	E. W. Miller, Milwaukee	x	x	x
	F. D. Murphy, Milwaukee	x	x	x
	G. W. Neilson, Milwaukee*	x	x	x
	E. F. Peterson, Wauwatosa*	x	a	a
	H. W. Powers, Milwaukee	x	x	x
	S. J. Seeger, Milwaukee	x	a	a
	F. A. Thompson, Milwaukee	x	x	a
	T. Willett, West Allis	x	a	a
Monroe	T. J. Sheehy, Tomah	x	a	a
Oneida-F-V	Gentz Perry, Rhinelander	x	x	x
Outagamie	V. F. Marshall, Appleton	x	x	x
Pierce-St. Croix	J. W. Prentice, Amery	a	x	x
	B. Kunny, Baldwin*	x	a	a
Portage	H. M. Coon, Stevens Point	x	x	x
Price-Taylor	E. A. Riley, Park Falls	x	a	a
Racine	H. B. Keland, Racine	x	x	x
Rock	P. A. Fox, Beloit	x	x	a
Rusk	W. F. O'Connor, Ladysmith	x	a	a
	R. C. Rodecker, Holcombe*	x	x	x
Shawano	A. J. Gates, Tigerton	x	x	x
Sheboygan	A. J. Knauf, Sheboygan	x	x	x
Trempealeau-J-B	C. F. Peterson, Independence	x	x	x
Vernon	R. S. MacKechnie, Hillsboro	x	a	a
Walworth	R. C. Halsey, Lake Geneva	x	a	a
Washington-Ozaukee	H. M. Lynch, Allenton	x	x	x
Waukesha	M. R. Wilkinson, Oconomowoc	a	x	x
Waupaca	T. E. Loope, Iola	x	x	x
Winnebago	J. W. Lockhart, Oshkosh	x	x	x
Wood	K. W. Doege, Marshfield	x	x	x

District	*Councilor*	1	2	3
First	A. W. Rogers, Oconomowoc	x	x	x
Second	G. Windesheim, Kenosha	x	x	x
Third	C. A. Harper, Madison	a	a	a
Fourth	Wilson Cunningham, Platteville	x	x	x
Fifth	O. B. Bock, Sheboygan	a	a	a
Sixth	F. Gregory Connell, Oshkosh	x	x	a
Seventh	Edward Evans, La Crosse	x	x	a
Eighth	T. J. Redelings, Marinette	x	x	x
Ninth	Joseph F. Smith, Wausau	x	x	x
Tenth	H. M. Stang, Eau Claire	x	a	a
Eleventh	J. M. Dodd, Ashland	x	x	a
Twelfth	R. W. Blumenthal, Milwaukee	x	x	x
	J. J. McGovern, President-Elect, Milwaukee	x	x	x
	Rock Sleyster, Treasurer, Wauwatosa	x	x	x

* Indicates alternate, x present, a absent.

Sep. 6—Fred Holmes	175.00		
Sep. 6—Fred Wylie	500.00		
Sep. 6—Wis. Med. Journal	162.90		
Sep. 6—Whitehead & Hoag Co.	326.70		
Sep. 6—Cannon Printing Co.	12.50		
Sep. 6—Dr. G. J. Hathaway	25.00		
Sep. 6—Wis. Printing Co.	325.85		
Sep. 12—Milwaukee Acad. of Medicine	48.00		
Sep. 12—Wisconsin Medical Journal	25.00		
Sep. 12—Wisconsin Telephone Co.	13.94		
Sep. 12—Astrid Jurgens	100.00		
	4,743.62	1,018.00	5,761.62
			6,113.85

Balance as per Treasurer's Books, Sept. 19, 1927:		
General Fund	$2,816.92	
Medical Defense Fund	3,296.93	
Total cash in bank	6,113.85	
Investment Securities listed in previous report		$18,000.00
Certificate of Deposit—1st Wisconsin National Bank Purchased August 15, 1927		2,000.00
Total in Investment Securities Sept. 19, 1927		20,000.00

SUMMARY OF FINANCES AS AT SEPTEMBER 19, 1927

Investment Securities	$20,000.00
General Fund	2,816.92
Medical Defense Fund	3,296.93
Total Cash and Investments	26,113.85

SPEAKER DOEGE: Any comment on this report? If not, I will entertain a motion for its acceptance.

DR. ROGERS: I move its acceptance.

The motion was seconded by Dr. Mauermann, of Monroe, and carried.

SPEAKER DOEGE: We will now listen to the report of the Secretary. His report has also been printed, but I believe the Secretary would like to emphasize some points orally.

SECRETARY CROWNHART: Before I start my oral report, Mr. Speaker, we have a letter from the Interstate Post Graduate Medical Association of North America to the gentlemen of the House of Delegates:

"Milwaukee, Wisconsin.
September 15, 1927.

"The State Medical Society of Wisconsin,
Eau Claire Hotel,
Eau Claire, Wisconsin.
Attention, Mr. J. G. Crownhart,
Secretary-Managing Editor.

"Gentlemen:

"The Officers and Board of Directors of the Interstate Post Graduate Medical Association of North America extend to the Officers, House of Delegates, and Members of the State Medical Society of Wisconsin greetings at this Eighty-Sixth Anniversary Meeting of the Wisconsin State Society.

"A most cordial invitation is herewith extended to the profession of Wisconsin to attend the annual assembly of the Interstate Association at Kansas City, Missouri, October 14 to 21, inclusive.

"Cordially and respectfully,
"EDWIN HENES, JR., M. D.,
Executive Secretary."

In the measurement of progress from year to year, it is not alone possible, but altogether probable, that we may give such attention to details that we overlook the degree of progress of the Society as a whole.

It is of importance that this Society saved each member twenty-seven dollars in the last nine months. It is of importance that we are meeting with distinct success in a lay educational program. It is of importance that the Society is growing in membership and strength. So might I, in repetition, point out the many steps of progress made by your Society during the last year, each of importance to the group or the individual. The record of the year, however, may be found in my report in the September Journal. It is my pleasure now to examine and bring to your attention briefly the growth of the organization as a whole and to what degree we are accomplishing its organizational purposes.

First, the organization has progressed to the point where no single piece of legislation inimical to a just medical practice or major public health progress will be adopted. This is the first time in our history when we could make such a statement.

Second, the State Society has secured the enactment of just laws governing practice. In speaking of this legislation last week, the Director of the College of Surgeons declared that Wisconsin was the first state to strike a death blow to quackery in practice. The Society has embarked on the work of securing for the public an effective enforcement of these laws. Much has been accomplished until fulfillment of this enforcement objective seems possible of attainment in the not distant future.

Third, the organization has reached a new understanding, and is rendering a service never before possible, in guarding and fostering the just material interests of the members.

Fourth, the councilor district meetings and the progress in the county meetings bear testimony to the promotion of friendly intercourse among members, and these with the state meeting, your Journal and the several extension services inaugurated during the past year bear out the statement that the Society has gone far in promoting medical knowledge and extending medical science.

Fifth, we have accomplished much in our service to the non-medical public in giving information as to what medical science has attained and placed at their disposal through the friendly offices of the family physician and specialist.

Thus we can summarize in a few words a progress which in detail has been a seemingly endless task to your officers who have given so much that these few words might be said.

In each of the above enumerated fields of purpose of the Society may the members expect progress in the future. It will come piecemeal, but with a structure well under way each added piece will seemingly give more in itself because it is added to that already built.

With the addition of each stone of accomplishment, your officers are given a newer and clearer vision of that possible of attainment in the future. More and more are your officers presently impressed with the fact that the problems of the very near future are going to be those of unprecedented importance to the welfare of the public and the individual member. We necessarily have been so occupied with immediate work that we have little realized and less attained the benefits that await those who will assume leadership of medicine in all its phases, for which work we now find ourselves ready.

Ignorance of scientific methods as found in individuals is of but small importance as compared with ignorance

carried into the body politic that we may anticipate as the public awakens to the possibilities of greater health and consequent wealth that scientific medicine now offers. It will be but natural if the desires of the laymen for immediate benefits do not blind them to ultimate failures, if the course is not charted wisely.

In the increasing strength of the Society will lie the ultimate solution of these larger problems of the present and near future. So does your Secretary urge upon this House and the members as individuals the desirability of further strengthening the component county and district medical societies to the end that when your officer-servants, charged with the duty and privilege of executing the group demand and collective aim, more and more find it essential to call upon the groups and individuals they will find them ready to respond to any call for action, strong in numbers and without superiors in the strength of individually adhering to the group aim. And that aim must continue to be one formulated each year in this representative House of Delegates in the interest of conservation of health and the greater prosperity that will come to those whose contributions in leadership and statesmanship, as in discovery, make possible its wider and still wider attainment. (Applause.)

SPEAKER DOEGE: This report is referred to the Committee on Reports of Officers.

We are now ready for the election of the Committee on Nominations. This committee, as you know, is composed of one member of each of the twelve councilor districts. I will ask the Secretary to name the counties of which each of these twelve councilor districts is composed, and I will then ask the members of each district to get together and nominate among themselves the member for the Committee on Nominations. When the nominations are concluded, we will have a motion to accept those members as the Committee on Nominations.

SECRETARY CROWNHART: As I read these names, will the members from these county societies please rise and then nominate among themselves one for a position on this committee.

First District: Dodge, Jefferson, and Waukesha Medical County Societies.

DR. ARTHUR ROGERS (Oconomowoc): I nominate Dr. H. O. Caswell, of Fort Atkinson.

SECRETARY CROWNHART: Second District: Kenosha, Racine and Walworth County Medical Societies. The only delegate is Dr. H. B. Keland, of Racine.

Third District: Dane, Columbia, Green, Rock, and Sauk County Medical Societies. Dr. J. F. Mauermann, of Monroe, is the only delegate present.

Fourth District: Crawford, Grant, Iowa, LaFayette, and Richland County Societies.

DR. WILSON CUNNINGHAM (Platteville): I nominate Dr. J. C. Betz, of Boscobel.

The nomination was seconded by Dr. A. J. McDowell, of Soldiers Grove.

SECRETARY CROWNHART: Fifth District: Calumet, Manitowoc, Washington-Ozaukee and Sheboygan County Medical Societies.

DR. H. M. LYNCH (Allenton): I nominate Dr. A. J. Knauf, of Sheboygan.

SECRETARY CROWNHART: Sixth District: Brown-Kewaunee, Door, Outagamie, Fond du Lac and Winnebago County Medical Societies.

DR. H. H. MEUSEL (Oshkosh): I nominate Dr. S. E. Gavin, of Fond du Lac.

SECRETARY CROWNHART: Seventh District: Juneau, La Crosse, Monroe, Trempealeau-Jackson-Buffalo and Vernon County Medical Societies.

DR. C. F. PETERSON (Independence): I nominate Dr. W. E. Bannen, of La Crosse.

SECRETARY CROWNHART: Eighth District: Marinette-Florence, Oconto, and Shawano County Medical Societies.

DR. A. J. GATES (Tigerton): I nominate Dr. G. R. Duer, of Marinette.

The nomination was seconded by Dr. T. J. Redelings, of Marinette.

SECRETARY CROWNHART: Ninth District: Clark, Green Lake - Waushara - Adams, Lincoln, Marathon, Portage, Waupaca, and Wood County Medical Societies.

DR. W. H. BAYER (Merrill): I nominate Dr. S. M. B. Smith, of Wausau.

The nomination was seconded by Dr. Joseph Smith, of Wausau.

SECRETARY CROWNHART: Tenth District: Barron - Polk - Washburn - Sawyer - Burnett, Chippewa, Eau Claire, Pierce, Rusk, and St. Croix Counties.

DR. W. C. HENSKE (Chippewa Falls): I nominate Dr. O. J. Blosmo, of Menomonie.

The nomination was seconded by Dr. F. E. Butler, of Menomonie.

SECRETARY CROWNHART: Eleventh District: Ashland-Bayfield-Iron, Douglas, Langlade, Oneida-Forest-Vilas and Price-Taylor County Medical Societies.

DR. J. M. DODD (Ashland): I nominate Dr. T. J. O'Leary, of Superior.

The nomination was seconded by Dr. Perry, of Rhinelander.

SECRETARY CROWNHART: Twelfth District, composed of the largest county medical society, with 550 members.

DR. J. O. DIETERLE (Milwaukee): I nominate Dr. R. W. Blumenthal, of Milwaukee.

The nomination was seconded by Dr. T. Willett, of West Allis.

SPEAKER DOEGE: I will now entertain a motion to declare these nominees to be the unanimous choice of the House for the Committee on Nominations.

DR. F. A. THOMPSON (Milwaukee): I move that this be the unanimous choice.

The motion was seconded by Dr. Henske, of Chippewa Falls, and carried unanimously.

SECRETARY CROWNHART: Mr. Speaker, while all the members of this committee are present, may I ask that Dr. Blumenthal act as temporary chairman, until you have a meeting, and that he come forward at the close of the meeting and secure the envelope with the list of positions to be filled and other actions to be taken by the committee, and that you hold a meeting in this hall at which time you elect your regular chairman and proceed to the order of business.

SPEAKER DOEGE: Before passing on to the next order of business, I will call public attention to the responsibilities resting upon this committee. On Thursday morning they will present a sealed report to this House containing their recommendations for a new President Elect, a speaker of the House of Delegates, and a vice-speaker of the House of Delegates, other officers, and the place of meeting for the year 1928. In behalf of the House, I extend to this committee its responsibility to choose without fear or favor, not only those who are deserving of the honor but those who will to the best of their ability discharge the responsibilities placed upon them.

The next order of business is the election of a delegate to the American Medical Association to succeed Dr. Joseph F. Smith, of Wausau, whose term has now expired. The Chair will entertain a motion.

DR. ARTHUR ROGERS: Mr. Speaker, I would deem it an honor and a privilege to nominate Joseph Smith to succeed himself. I so move.

The nomination was seconded by Dr. Mauermann.

SPEAKER DOEGE: You have all heard the motion. Are you ready for the question? Those who are in favor say "Aye"; contrary, "No". The motion is carried.

We will now proceed to the election of alternate delegate to succeed R. E. Mitchell, of Eau Claire, whose term has expired. The Chair will entertain a motion to that effect.

DR. O. J. BLOSMO (Menomonie): I nominate Dr. H. M. Stang, of Eau Claire.

DR. STANG: I withdraw, and would like to nominate Dr. Mitchell to succeed himself.

DR. WILLETT: I move the nominations be closed.

The motion was seconded by Dr. Arthur Rogers, and carried.

SPEAKER DOEGE: I believe that Dr. Blosmo's motion did not receive a second. So that leaves the nomination of Dr. Mitchell before the house. All who are in favor may say "Aye"; contrary, "No". It is carried.

While there is a constitutional amendment pending before the house relating to the election of councilors, it does not affect, even though adopted, the election for this year. The next order of business, therefore, is the election of councilors for the following districts: Eleventh, to succeed Dr. J. M. Dodd, of Ashland. Twelfth District, to succeed Dr. Hoyt E. Dearholt, of Milwaukee. First District, to succeed Dr. Arthur W. Rogers, of Oconomowoc. Second District, to succeed Dr. Gustave Windesheim, of Kenosha.

While the election of councilors is by the entire house, it has been customary to have all the nominations come from delegates in the district affected. This House will now recess for five minutes, during which time the delegates will meet in their respective corners of this room to present their nominations.

(A recess of five minutes.)

SPEAKER DOEGE: The Chair will now entertain nominations for a councilor to succeed Dr. John M. Dodd, of Ashland.

DR. H. G. MERTENS (Bayfield): I nominate Dr. Dodd to succeed himself.

The nomination was seconded by Dr. O'Leary, of Superior.

SPEAKER DOEGE: Any other nominations?

DR. PERRY (Rhinelander): I move that the nominations from the Eleventh District be closed, and that Dr. Dodd be declared the choice of the House.

The motion was seconded by Dr. Mertens.

SPEAKER DOEGE: You have heard the motion. Those who are in favor say "Aye"; contrary, "No". The motion is carried.

Nominations are now in order from the Twelfth District to succeed Dr. Hoyt E. Dearholt, of Milwaukee.

DR. F. A. THOMPSON (Milwaukee): As chairman of the delegation from Milwaukee, we have already met in Milwaukee and prepared our nomination. But before doing so, the delegation from the Twelfth District wishes to acknowledge the long, faithful, and beautiful service that Dr. Dearholt has given to the Society. I have here a letter which was written by him to Dr. Stoddard:

"I desire to retire from the council of the State Medical Society at the expiration of my term, at the coming meeting. I am telling you this, at the request of the County Society at this time, in order that you may have an opportunity to take such steps as you wish to make the best selection of a successor."

On September 15, Dr. Robert W. Blumenthal was nominated by the Twelfth District. I so move.

The nomination was seconded by Dr. H. W. Powers, of Milwaukee.

SPEAKER DOEGE: The motion has been made and seconded to nominate Dr. Blumenthal, of Milwaukee. All in favor say "Aye"; contrary, "No". The motion is carried.

Nominations from the First District to succeed Dr. Arthur W. Rogers, of Oconomowoc.

DR. H. O. CASWELL (Fort Atkinson): I nominate Dr. Rogers to succeed himself.

The nomination was seconded by Dr. Joseph Smith, of Wausau.

SPEAKER DOEGE: Motion has been made and seconded that Dr. Arthur W. Rogers be elected to succeed himself. All in favor say "Aye"; contrary, "No". The motion is carried.

Nominations from the Second District to succeed Dr. Gustave Windesheim, of Kenosha.

DR. H. B. KELAND (Racine): I wish to nominate Dr. Frank W. Pope, of Racine, to succeed Dr. Windesheim.

The nomination was seconded by Dr. Windesheim, of Kenosha.

SPEAKER DOEGE: All those who are in favor of the nomination of Dr. Pope say "Aye"; contrary, "No". The motion is carried.

DR. WINDESHEIM: The members of the Second District have known for some time that I would like to retire from the council. At the meeting of the Second District Medical Society last fall they nominated Dr. Pope, of Racine, to succeed me on the council. Consequently I seconded the nomination.

SPEAKER DOEGE: Pursuant to action by the 1926 House of Delegates, there is now pending before this House an amendment to the Constitution. This amendment, introduced by Dr. Otto Fiedler, of Sheboygan, at Madison last year, was laid on the table a year, as provided by the Constitution. All county societies have been notified of its contents, as provided. We are now ready

for action. The amendment, as introduced, adds the following statement to Chapter IV, Section 1, of the By-Laws:

"Councilors shall be elected by their respective council or district societies at sessions held prior to the annual meeting of this Society or in default thereof by the House of Delegates."

Is there any discussion?

SECRETARY CROWNHART: Mr. Speaker, I would like to suggest that on an amendment as important as this, the delegates, especially those who are new members, should feel perfectly free to express their opinions or the opinions of their society.

DR. G. R. DUER (Marinette): At the meeting of our county society this matter was brought up and discussed thoroughly, and I have been instructed to vote against the amendment for this reason, although it seems to be more democratic and perhaps theoretically more practical. The members of our society felt, after careful consideration, that the old method which has been used for many years and has proved satisfactory might well be continued. They felt that it would be practically impossible to get our members together in our district at a meeting which would be representative in order to make this selection, and they felt that the present method, which has been so satisfactory, should be continued.

DR. W. E. BANNEN (La Crosse): When this amendment was before the House last year, I perhaps made myself conspicuous by a fight that I carried to have this amendment defeated, and which perhaps had something to do with its being laid upon the table. I am in somewhat of a paradoxical position at this time, because I am here instructed to vote for the amendment. I still feel, as I did last year, that a caucus of delegates as have been meeting here tonight and selecting a member for the council is a more representative caucus and a caucus that is far more conservative and takes far better consideration of the man who is nominated for the special position as councilor for his district; knowing as I do and knowing as you all do how the nominating committee of the district society nominates their officers, I can say this. At the last meeting of the seventh district I left the meeting and went off to another meeting, and had the presidency wished upon me in my absence. I believe that the councilors of the State Society are more carefully selected by these delegates from the different counties who represent their societies here than the delegates or the councilor will be appointed by the meeting of the district society. I still feel that the old method of selecting the councilors is superior, although I am instructed to vote for the amendment. I believe that the amendment should be defeated.

DR. JOSEPH F. SMITH (Wausau): I should like to ask for information. I should like to know, and I imagine there are a good many others here who would like to know, what the status of this election would be in case this amendment fails.

SECRETARY CROWNHART: I think I can answer that for you, Dr. Smith. Under the Constitution at the present time the councilors are elected by the House of Delegates. It is not in the Constitution, but it is a precedent that is always followed that nominations for councilor of any district shall come from the delegates, after a caucus, of the district affected by the election: So that while the election is by the House as a whole, the nomination comes from a caucus of the delegates of the district affected. Four are elected each year. It used to be two were elected for a term of six years. The new Constitution adopted last year changed it so that four are elected each year for a term of three years.

DR. WILSON CUNNINGHAM (Platteville): In the nominations by the district society, in many sections of the state, or a number at least, there are few, if any, district society meetings, and when those meetings are held they are usually attended by one county. I know in my own case when there is a district meeting it is attended mostly by members of the profession of the county in which the meeting is held, and in that way the counties would not be well represented, not as well represented as they are by being represented by their delegates in the House of Delegates.

DR. DEARHOLT (Milwaukee): As an ex-member of the council, I would like to say a word. One of the reasons why I was anxious not to be continued as a councilor from the Twelfth District at this meeting was in order that I might feel a little more free to speak upon this amendment than I would if I were personally involved in the question. I have been a member of the council now for a great many years, have been quite faithful in attendance at these meetings, and have watched the deliberations of that body. I am pretty well satisfied in my own mind that we have one of the very best state medical societies in the United States. I think it has been made so very largely by certain men who have acted as wheel horses in that society, carrying the responsibilities year after year for the society.

Personally, I think we have gone about as far in the way of popularizing the council as we should go at this time, the length of term being cut from six years to three years. It would seem to me an act of wisdom when we have a society that is, I think, unquestionably one of the best in the country and one of the best in this section of the country, that we be rather slow and loath to swap horses too much. And I recommend that, from my experience, as I say now quite impersonally since I am no longer on the council, this amendment be deferred at least until such time as there is an opportunity to work out the constitutional provisions as now exist and see whether it is desirable to still further change the administration of the State Medical Society. I hope this amendment will not be made.

DR. ROCK SLEYSTER (Wauwatosa): I should like to speak against this motion, myself. We have in this country probably the greatest and most successful scheme of medical organization the world has ever known. A scheme of organization that has been carefully studied out, not only by our state but by every state in the union, and it has been felt universally that the councilors are to be elected by the House of Delegates. Now the Constitution and By-Laws which have been provided for by the American Medical Association, after most careful study and deliberation, provide for this method of election.

The second argument I wish to present is the fact that the district society is a purely scientific organization, not

a legislative body. The scheme of medical organization calls only for legislative action on the part of the county society, the state society, and the A. M. A. The district society is purely a scientific organization.

The third argument I wish to present is this: Your council is a board of trustees, a board of directors, for your state society. It is not responsible to the district society. It is responsible only to this House of Delegates. It is the men whom you elect to carry on your business and your affairs during the year when you are not in session. This report is to be made to you and they are responsible only to you. I think it would be a serious mistake to change this scheme of organization in this state. It is not done anywhere else. I think it is perfectly proper the district society should make nominations and send their delegates instructed to nominate the men they wish to represent them on the council, but the election should be made by this body, because the council is your board of directors and responsible only to you.

DR. C. F. PETERSON (Independence): I think I hold a position just a little bit different from any of the speakers who have spoken here. I think most of them are delegates or councilors from large cities. I come from a little town, a little county society, where we have not any large city, and you might wonder how we feel on this question. In our district, with La Crosse as the largest city, it is the place where the meetings are usually held, and whenever that question should come up it is the La Crosse people there who are in control of that meeting. I can see also how there is just a little fight on occasionally. They may have a grudge against some good man, and how they clique to go out and oust that good man. My position is just a little different from that of Dr. Bannen. I have not been instructed, and I am just going to vote the opposite to what he is. I will vote against this amendment if it comes to a vote. We are well satisfied, and I believe that our mode of electing councilors is just as good as any you can devise. The delegates here surely should represent their local societies. If any important question comes up in the House of Delegates, I talk it over with the members of the society to which I belong, and I am sure I am going to represent them. Now I think I made myself clear. I can see even at this meeting every now and then there is just a little strife on, probably a grudge against some particular councilor, probably some local trouble, some rivalry, and how they group together to oust that man, although that man may be the best man for that particular district or the council.

DR. J. F. MAUERMANN (Monroe): I came here instructed, and I would move this amendment to the Constitution be laid over for another year.

The motion was seconded by Dr. Arthur Rogers.

DR. H. W. POWERS (Milwaukee): I don't see why this should not come to a vote now. I don't see why it should be brought up and occupy the time of the delegates at another meeting. We have heard enough about it to form a reasonable opinion, and we can express that opinion tonight.

DR. T. J. REDELINGS (Marinette): May I just rise to say that if it should develop we have been in error in defeating this amendment, which I think should be defeated, it can be easily revived at a subsequent time. It seems the part of wisdom not to make the change at present.

DR. F. A. THOMPSON (Milwaukee): We of Milwaukee came with our action all taken on the councilship. I noticed in this roll call that there were one and two and three representing a great area of the state. It seems that if we are going to vote intelligently as a unit this body should be the unit. The responsibility goes back to your society to see that your delegates are here. If they have a caucus before the election, they are well instructed and well informed as to the wishes of the society.

DR. A. J. GATES (Tigerton): I came as a delegate instructed from Shawano County, and feel on both sides of the question. No matter which way I would vote I don't think I would express the opinion of all the doctors at home, and I really think it is a very delicate question. If we were all situated in larger towns, as the previous speaker said, I really believe we ought to have the change, because we would all have a chance to get together and talk things over, and really would be much more able to decide upon the proper man. In the district I am in, the Eighth District, we very rarely all get together. We have our little meetings in our county, and I suppose the other two counties have their meetings. If our district could have a great representative meeting, so all the doctors of that whole district were there, or most of them, then I would be in favor of the change, because I really think we have a chance to dig this thing up and have a good man. As it stands, I hardly know how to vote. I want to be frank about it. Personally, I would like to be very democratic in the matter, but as far as the Society is concerned as a whole, as a Wisconsin State Society, knowing as I do we have a wonderful society, I wouldn't like to throw a monkey-wrench into the workings of the Society by my vote. You can see that I for one am not sure just how I do want to vote. It is not a simple problem.

Dr. Sleyster's arguments are good, but I do think there is one little argument on the other side. That our old system naturally makes it a sort of a sameness. Naturally when there are only two or three men they are not going to get out and vote down a man. They are going to try to have the same man over and over again. I am not talking against that. We have often heard it said that the delegates who go to the A. M. A. ought to be the same fellows all the time. We know that is good, because they know their lesson and know their business and ought to go back. Whether it is always the right thing, I don't know. There might be times when there should be a change. I am not going to argue that. I know the representatives and know the members of the council, and don't think we could better the council.

The question was called for.

SPEAKER DOEGE: The motion has been made that the resolution be laid on the table for another year.

SECRETARY CROWNHART: Mr. Speaker, under the proper head the motion should be: shall the amendment be adopted, but a motion to lay on the table is always in order, so the motion is correct as the Speaker stated it: shall the amendment be laid on the table for another year?

SPEAKER DOEGE: We are voting on Dr. Mauermann's motion to lay the motion of Dr. Fiedler on the table for another year. All in favor say "Aye"; contrary, "No".

(Result undetermined.)

SECRETARY CROWNHART: I think, to help the Speaker out, we will have a division. Will all those in favor of the motion please stand. (Nine.) Will those opposed please stand? (Fifty-one.) The motion is defeated. Are you ready for the question on the amendment? The question is, so they get it clearly, shall the amendment be adopted?

SPEAKER DOEGE: Dr. Fiedler's amendment. All those who are in favor say "Aye"; contrary, "No". The amendment is lost.

SECRETARY CROWNHART: I notice we have present one or two I want to introduce. Mr. Arthur Hedquist, of the Chamber of Commerce of Eau Claire, who made this meeting possible from the standpoint of housing. (Applause.) Sitting down here is Dr. Sidney Hall, Treasurer Emeritus of the State Medical Society. (Applause.)

SPEAKER DOEGE: This house is now under the head of new business. As the first order, it is indeed a pleasure to call upon your President, Dr. A. W. Rogers, and ask him to rise and present to this House any recommendations that may have occurred to him during his nine months as president.

PRESIDENT ROGERS: Mr. Speaker and Members of the House of Delegates: It seems to me this is a most appropriate time and place to express my sincere appreciation of the very great honor that our State Society saw fit to confer upon me. I have been a traveling man for the last seven months, and I have been pretty much up and down the state and across the state. I attended every district medical meeting but one, and then two met on the same date so I couldn't attend both. I want to say, gentlemen, that I have been met everywhere with the utmost sympathy, cordiality, and cooperation, and the only address I have got is this: I am very proud of the Wisconsin State Medical Society.

Your officers beg to report the results of their stewardship for the past seven months. I have endeavored to arrange the topics of this report in the order of their importance as they present themselves to me.

First, the legislature just closed was very kind to us. Most of the bills introduced have become laws. Two very important bills were vetoed by the Governor, but we feel that the work done in their behalf was not lost, but will go far toward their successful passage in the future.

I wish to register at this point my personal appreciation and admiration of the indefatigable and diplomatic manner in which the entire matter of legislation was managed by our Secretary, Mr. Crownhart.

Second, University Extension. This important matter, fully outlined for you in a recent number of the State Journal, has been slumbering for some years, but during the year it has been revived and placed upon a firm foundation. Another year will find it in full operation. This is a subject which will warrant the closest study and investigation by members of the State Society, in order to utilize to the fullest extent the various excellent opportunities it affords.

Third, Periodic Health Examinations. As most of you know, a meeting was held early in the year for the purpose of fully canvassing this subject, dividing the state into districts, and designating certain members to make demonstrations. This has worked out very satisfactorily, and the state has been well covered. Likewise, much work has been done along the same lines in educating the public.

Fourth, the nursing problem has been given close and intensive study, and the report of your committee should be given hearty endorsement.

Fifth, an effort has been made to check the press in the undesirable publicity given to suicides. The editor of every daily paper in the state received a letter calling his attention to the harmful effects of suggestion along these lines. Most of the editors replied favorably, and we feel that no inconsiderable good was accomplished. It is only by continually hammering at this curse that permanent good can result.

Finally, we come to a suggestion and recommendation. There may be a real danger in too frequently recounting and priding ourselves on our accomplishments. The danger lies in the possibility of its clouding our vision and thereby interfering with our development. Our Society will continue to increase in members and to grow in influence. Growth means more work, a greater number of workers, and means to work with. The day is at hand when a one-man secretary can barely discharge efficiently the duties required of him. We need funds to bring desirable speakers to our meetings, funds to assist the Board of Medical Examiners in ridding the state of nefarious quacks, funds to promulgate the subject of periodic health examinations and extend lay education, and funds for many other purposes. Our dream is to devise ways and means to these ends.

The Interstate Post Graduate Assembly and the Michigan State Medical Society have found it necessary to organize a foundation to carry on their work properly. Wisconsin has long had the reputation of being a pioneer and an aggressor in everything progressive, and we, as medical men, should endeavor to maintain this reputation.

The time is ripe for the establishment of a State Society Foundation which as it develops will give its members an opportunity to turn funds into this Foundation for the furtherance of the worthy projects of our organization. I know a member who will contribute the first five thousand dollars toward such a foundation when organized and who will arrange through his will to contribute twenty thousand more. I recommend this suggestion to the serious consideration of the delegates. (Applause.)

I did not act impulsively on this matter of foundation, but in correspondence with Dr. Olin West, the Secretary and General Manager of the A. M. A., I wish to read a letter signed by Dr. West.

"Chicago, Illinois,
September 13, 1927.

"Dr. Arthur W. Rogers,
Oconomowoc, Wisconsin.
"Dear Doctor Rogers:

"I am very glad indeed to have your letter of September 12. I regret very much that I did not catch the full meaning of the last paragraph in your first communication. Somehow I received the impression that it had to do with the subject matter of the first part of the letter.

"I also regret that I have very little detailed information concerning the fund which the Michigan State Medical Society has created as a general purpose fund. I have for years, however, advocated the establishment of such a fund by state medical associations, provided such a fund could be gathered together without interfering with the immediate needs and progress of the association and without imposing too large an expense on the individual member.

"In these unsettled times no organization can go very far wrong in providing for emergencies of any kind. We seem to be passing through a period of reaction and readjustment, and it is difficult to make wise decision with respect to permanent policies, or to foresee what even the near future may have in store. The wise thing, it seems to me, is to make provision for whatever may come by setting aside funds which may be used on the reasonable demands of any new situation that may develop.

"Aside from this view of the question, it seems wise also for any organization that can secure funds, in addition to those needed for ordinary procedures, to create a surplus that can be drawn upon to advance the application of methods that have already proven their efficiency.

"The State Medical Society of Wisconsin has made remarkable progress in practically every field of organizational activity. No doubt some of the movements that have been undertaken have proven their lasting value and have become a part of the permanent policy of the Society. Perhaps some others have not panned out as desired. These, of course, will have to be abandoned or supplanted by other movements and methods. However, one may look at the proposition in its wider aspects. One would seem to be justified in the conclusion that it is wise for any medical society which intends to be progressive and successful to put itself into a position whereby it can deal in due time with practically any situation that may arise. That means, of course, the establishment of reserve funds. The American Medical Association has pursued this policy with respect to its finances and is coming to occupy a strong position.

"Of course, there is always the disposition on the part of some men to encroach on any considerable sum that may be gathered together for any general or specific purpose, and this has to be constantly kept in mind by those who are charged with the duties of guarding such funds as may be created.

"A number of the constituent state medical associations have surplus funds, some of which have been set aside for specific purposes, which were worthy at the time the funds were established, but which are not of any particular importance at the present time. These are simply piling up money year after year that is not producing anything and not accomplishing any worth while purpose. Other state associations have succeeded in building up surplus funds that have been drawn upon from time to time to meet the demands of unforeseen situations which have developed rather suddenly and have had to be dealt with.

"I believe that the Council of the State Medical Society of Wisconsin can be depended on to act with good judgment and with what might be called aggressive conservatism and, if I were a member of the Wisconsin organization, I would enthusiastically approve the establishment of a surplus fund, the expenditure of which would be left to the judgment of the Council.

"With most cordial good wishes, I am

"Very truly yours,

"Olin West."

My idea in this matter, gentlemen, was the idea of looking to the future. We cannot grow and be progressive without meeting the requirements as they come along, and those requirements are becoming so great that it will mean in the near future either raising of our dues or raising of funds otherwise. It is not my idea in making this recommendation to go to the rank and file of our Society for funds, but simply to have a committee appointed to study and investigate the creation of a foundation, opening an opportunity for those members who during life or through a will are willing and anxious to contribute funds for the various purposes which the Society may find.

My idea, furthermore, was that the Council should act upon the distribution of these funds so that they would be properly disbursed for purposes which seem honorable and desirable. I thank you. (Applause.)

SPEAKER DOEGE: These recommendations made by Dr. Rogers will be referred to the Committee on Report of Officers.

Under the new constitution all committee appointments are hereafter made by the incoming president. This year Dr. McGovern will nominate for all committees. Hereafter each incoming president will replace one man on each committee. These appointments are subject to confirmation by the House of Delegates. We will now receive the nominations from Dr. McGovern, president for 1928.

PRESIDENT-ELECT McGOVERN: Mr. Speaker and Members of the House of Delegates: I cannot express to you my appreciation for my election as President-Elect, and the opportunity to be President during the year 1928. We all agree with the remarks by Dr. Rogers, that it is a wonderful honor, something in which we have to spend every bit of energy that we have to meet the requirements of this wonderful Society at this time. I have a list of the committee assignments. There are three members for each committee.

Committee on Scientific Work
Dr. S. J. Seeger, Milwaukee, 1930
Dr. A. W. Rogers, Oconomowoc, 1929
Dr. H. P. Greeley, Madison, 1928

Committee on Public Policy
Dr. O. B. Bock, Sheboygan, 1930
Dr. Dexter H. Witte, Milwaukee, 1929
Dr. D. L. Dawson, Rice Lake, 1928

Editorial Board
Dr. Oscar Lotz, Milwaukee, 1930
Dr. Joseph F. Smith, Wausau, 1929
Dr. Hoyt E. Dearholt, Milwaukee, 1928

Committee on Medical Defense
Dr. Arthur J. Patek, Milwaukee, 1930
Dr. G. W. Nott, Racine, 1929
Dr. E. C. Cary, of Reedsville, 1930

Committee on Medical Education and Hospitals
Dr. C. R. Bardeen, Madison, 1930
Dr. L. F. Jermain, Milwaukee, 1929
Dr. Joseph W. Lambert, Antigo, 1928

Committee on Medical Economics
Dr. J. F. Wilkinson, Oconomowoc, 1930
Dr. T. J. O'Leary, Superior, 1929
Dr. Ralph Sproule, Milwaukee, 1928

Committee on Health and Public Instruction
Dr. W. D. Stovall, Madison, 1930
Dr. R. E. Mitchell, Eau Claire, 1929
Dr. H. C. Werner, Fond du Lac, 1928

Committee on Necrology—no appointment

Committee on Study of Nursing Problems
Dr. C. H. Stoddard, Milwaukee, Chairman
Dr. L. F. Jermain, Milwaukee
Dr. Joseph Evans, Madison
Dr. R. C. Buerki, Madison

Committee on Licensure of Hospitals
Dr. R. W. Blumenthal, Milwaukee, Chairman
Dr. C. A. Harper, Madison

I have been giving the subject a little thought since the last meeting in Madison, and I have given a few suggestions to the Council. They have adopted a suggestion that I offer here.

As President-Elect, it seems to me that the State Medical Society of Wisconsin is now in position, possibly for the first time, in behalf of the profession of the state, to offer cooperation and help to those lay organizations in the state who are concerning themselves with some phase or phases of the public health question. During the year the American Medical Association held a conference at its headquarters for executives of national organizations interested in like fields. This first conference was confined to the work of ascertaining just what each organization was attempting to do and had planned for the future.

It is now my suggestion, approved by the Council, that there be held in Milwaukee during January of 1928 a two-day session of executives of public health organizations interested in any phase of public health work, official or non-official. It is my suggestion that this conference be held at the State Medical Society headquarters, Medical Arts Building, upon invitation of the Society, with the thought that the first session will be devoted solely to statements by invited guests on the work their organizations are doing and the work their organizations contemplate.

Organizations who would be invited to send representatives would include, of course, the State Board of Health, the Kiwanis Club, the Shriners, the State Labor Council, the Federation of Women's Clubs, the Wisconsin Anti-Tuberculosis Association, the association interested in the field of crippled children, the State Board of Control, and like official and non-official organizations.

It seems to me that the tendency of such a conference, held upon invitation of the State Society, will be to further an understanding between the laity and the profession of the work that needs to be done, to ascertain possibilities for medical aid in worthy projects and to bring about eventually the close cooperation which should exist among all who are interested in furthering public health ideals. (Applause.)

SPEAKER DOEGE: The latter part of Dr. McGovern's address will be referred to the Reference Committee on the Report of Officers.

You have heard the nominations for the various committees. What is your pleasure?

SECRETARY CROWNHART: Mr. Speaker, for the information of the House, the new constitution requires that all nominations of the President be confirmed by the House. If there is any objection to any one, they can be confirmed singly or as a group.

DR. WILSON CUNNINGHAM (Platteville): I move that the nominations made by the President-Elect be adopted.

The motion was seconded by Dr. Mauermann, of Monroe, and carried.

SPEAKER DOEGE: Under the Constitution, this House must set the dues for each succeeding year. Without objection, I refer this to the Reference Committee on Resolutions. Further, without objection, I refer the report of the Special Committee on the Study of Nursing Problems to the Reference Committee on the Report of Standing Committees.

We are now ready for any new business. Resolutions may now be presented. Any received will be read by the Secretary, after which they shall be automatically referred, without discussion, to the Reference Committee on Resolutions. They may be fully discussed when that committee reports tomorrow evening.

DR. J. O. DIETERLE (Milwaukee): I have an amendment to present.

SECRETARY CROWNHART: Dr. Dieterle, of Milwaukee, proposes an amendment to the Constitution, which after being read, will lie on the table until the next annual meeting of the Society.

"WHEREAS, the Constitution adopted by the State Medical Society of Wisconsin at its 1926 meeting does not include past presidents of the State Society as members of the House of Delegates; and

"WHEREAS, it is most desirable that those who have served the State Medical Society in the capacity of president be full members of the House of Delegates for all time thereafter, the following amendment to the constitution is respectfully proposed:

"Amend Article V of the Constitution by adding at the paragraph a comma, striking out the period, and further adding the words, 'and (3) past presidents of the Society.'

"If the amendment is adopted, the section will then read:

"ARTICLE V
"HOUSE OF DELEGATES

"The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county societies, and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and (3) past presidents of the Society."

SECRETARY CROWNHART: This automatically lies on the table for one year, Mr. Speaker.

DR. SLEYSTER: I wonder if Dr. Dieterle would be willing to accept the amendment that they be without power to vote, ex officio. The House represents the government, and the amendment interferes with the whole scheme of things. My suggestion is the provision of the old Constitution.

DR. DIETERLE: I will accept that amendment.

The amendment, as revised, reads:

"Amend Article V of the constitution by adding at the end of the paragraph a comma, striking out the period, and further adding the words 'and (3) past presidents of the Society ex officio.'

"If the amendment is adopted the section will then read:

"ARTICLE V
"HOUSE OF DELEGATES

"The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county societies, and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and (3) past presidents of the Society ex officio."

SPEAKER DOEGE: If there are any other resolutions, we would like to have them at this time, or the sense of them that they may be referred to the Committee on Resolutions, which will present its report tomorrow night.

DR. THOMPSON: Dr. McMahon has something to present to you which may be passed under the head of a resolution.

DR. JOSEPH P. McMAHON (Milwaukee): Mr. Speaker and Members of the House of Delegates: I thank you for the privilege of appearing and presenting the subject which I desire to bring to your attention. The older members of the House and of the Council would probably leave the meeting laboring under the impression that there was something seriously wrong with me if I did not make some remarks before the House with reference to the subjects of graduate instruction for members of the profession on the early diagnosis of cancer and the education of the laity on the early suggestive symptoms of cancer. As some of you will recall, Dean Bardeen appointed an extra constitutional committee on cancer during his tenure as President in 1920. When the new constitution and by-laws were read a year ago, your humble servant suggested that the cancer committee be abandoned and that its work be assigned to a sub-committee of the committee on health and public instruction. If my memory serves me, this suggestion was adopted.

The matters to which I wish to call your attention at this time are as follows: A national association for the control of cancer, sponsored by well known colleagues and prominent laymen, among whom are Chief Justice Taft, Frederick L. Hoffman, and George E. Vincent, was organized approximately fifteen years ago. The history of this organization, so far as Wisconsin is concerned is briefly as follows: Wisconsin belonged to the so-called central district, the first chairman of which was Dr. Fred T. Murphy, then professor of surgery at Washington University—Dr. Murphy appointed Dr. J. L. Yates chairman for Wisconsin—Dr. Yates served a couple of years and then resigned—Dr. Joseph F. Smith and other presidents, working in conjunction with the national association, asked me to accept the chairmanship for Wisconsin. For reasons then existing I was unable to accept. On August 31st of this year a communication was addressed to me by the American Society for the Control of Cancer which reads as follows:

The American Society for the Control of Cancer
25 West 43rd Street, New York City

"Dr. Joseph P. McMahon, "August 31, 1927.
Wells Building,
Milwaukee, Wisconsin.
"Dear Doctor McMahon:

"This society is at present without a chairman for the state of Wisconsin. You have been highly recommended to us for the position, and we should like to know if you would care to consider a possible appointment.

"Inasmuch as we desire to have the hearty support of the State Medical Society and to work in harmony with the organized medical profession, we believe it might be an advantage to have the chairman of the cancer committee of the State Medical Society also function as the state chairman of the American Society for the Control of Cancer. In this way, we believe it will be possible to develop a joint program which will satisfactorily promote the interests of both organizations.

"The program of this Society includes educational activities among both the medical profession and the laity. In some states, intensive programs are conducted at intervals; in other states, there is a continuous program of an extensive character.

"These programs include lectures to the profession and the laity, cancer symposia in connection with state and county medical meetings, special cancer clinics held under the medical society auspices, the preparation of newspaper articles, the distribution of literature, the showing of motion pictures and lantern slides, and similar educational features.

"This Society can be of assistance to its state chairman in many ways. All the experience which we have gained during the last fourteen years throughout the United States is at your service. We are constantly producing printed matter, both for the profession and the laity, and can supply a sufficient quantity to meet your needs. We also have moving pictures and exhibit material.

"Just what is done in each state depends not alone upon the needs as we see them in our national office, but what our local chairman find it desirable and practicable to accomplish. Consequently, we look to our state chairman to make the plan which is most suitable to his territory.

"In developing an organization, it is usually desirable to divide the state in accordance with the county boundaries, or the congressional districts, or the councilor districts of the state medical society, depending upon the conditions which obtain in the particular state. The state chairman appoints a local chairman for each county or district, and the local chairman appoints his committees to aid him in conducting the program.

"We appreciate the fact that the cancer committee of your state medical society has been doing some good work, but in order to avoid duplication of effort and to bring our forces more closely together, it seems advisable to combine our efforts with those of the state medical society. This has already been done in certain states with very satisfactory results.

"Will you kindly let us know whether you would care to consider a possible appointment as our state chairman for Wisconsin? "Very sincerely,

"GEORGE A. SOPER, Ph. D.,
Managing Director."

The reasons which prompted me to decline the chairmanship in the past still exist, but I am of the firm belief that the American Society for the Control of Cancer should have representatives, or at least a representative, in this state acceptable to, or better, nominated by the House of Delegates of the State Medical Society. It is indeed a rather anomalous situation not to have the State Medical Society of Wisconsin represented in the deliberations of such an ideally conceived and results securing organization as this one has proven to be.

Shortly after the last annual meeting I took up the question of continuing the attempt to educate the laity on the early suggestive symptoms of cancer with Dr. Stovall, chairman of the committee on health and public instruction, and while Dr. Stovall volunteered personal cooperation, I was not in a position to undertake the work which we believed should be done and, consequently, so far as I

am aware, nothing was done during the last year. It seems to me that, under the present by-law provisions for committees, the House of Delegates should consider empowering the incoming president to appoint a young general surgeon on the committee on health and public instruction who would undertake to discharge the duties of chairman for Wisconsin for the American Society for the Control of Cancer. I discussed this suggestion with my colleagues coming up on a train this afternoon and the majority of them agreed. The modus operandi of the bringing about of this appointment, if indeed you decide to do it at all, is, of course, a question for the delegates to determine. I am confident that there are a number of young general surgeons whose interest can be enlisted and who would carry the work on over the necessary period of years. In casting about for a desirable appointee one would naturally consider the professors of surgery at our medical colleges. I feel sure that there are young surgeons located in the several centers of population in the state, some of whom are affiliated with "Clinics" such as the clinics at Ashland, Marshfield, Oshkosh, Fond du Lac, Sheboygan, Kenosha, and La Crosse, who would discharge the duties of the chairmanship in a fruitful manner. With these remarks I submit the question for your consideration.

In conclusion: I desire to improve the opportunity to impress upon you the fact that the efforts of the National Society for the Control of Cancer and the efforts of any chairman or committee whom you may appoint will not avail to the fullest possible extent unless the members of the component county medical societies continue their interest in the subject and improve and make opportunities to appear before lay audiences in their respective communities until such time as the great majority of our citizens shall have an understanding of the early suggestive symptoms of cancer in the more frequent sites in which it appears.

I brought a sufficient number of complete sets of recently arranged literature on the early symptoms of cancer for distribution to the laity, so as to enable Secretary Crownhart to place one set in the hands of each delegate. Each separate piece of literature contains a notation of the cost per thousand. The price is so reasonable that county medical societies can secure all the pamphlets necessary for distribution in a given year for an appropriation of approximately $50.00. (Applause.)

SPEAKER DOEGE: Gentlemen, you have heard the recommendations and suggestions made by Dr. McMahon. What is your pleasure?

SECRETARY CROWNHART: Mr. Speaker, to expedite business, may I make this suggestion, that if the House wishes to adopt the suggestion they do that first or else reject it. If adopted, they call on the Committee on Nominations to bring in a suggestion of one or more to fill the position. That is purely a suggestion, Mr. Speaker.

SPEAKER DOEGE: Any remarks?

DR. H. W. POWERS (Milwaukee): I move that it be the consensus of opinion of the delegates that this is a laudable project, and that it be referred to the proper committee or the proper officers. If I understand that right, this would fall within the purview of the Committee on Public Health, by addition of a particular individual to that committee. If I am correct, such addition to the committee would be under the President-Elect. I then move that it be the sense of the meeting that this is a laudable project and that it be referred to the proper committee or officer.

The motion was seconded by Dr. Stang, of Eau Claire.

SPEAKER DOEGE: You all have heard the motion. Are you ready for the question? All those who are in favor say "Aye"; contrary, "No". The motion is carried. We will refer that to the Committee on Public Health.

Secretary Crownhart made some general announcements regarding registration and the place of meeting.

DR. H. M. STANG (Eau Claire): It occurred to me while sitting here that probably it would be appropriate that we recognize the work that has been done by the State Medical Society in getting rid of some of the quacks, and I move that the House of Delegates go on record thanking the State Board of Medical Examiners for what they have done. I am sure that something will come out of that in the future and the work will go on.

The motion was seconded by Dr. O'Connor, of Ladysmith, and Dr. Evans, of La Crosse, and carried unanimously.

SPEAKER DOEGE: Is there any new business? Any further resolutions? Any business of any kind? If not, a motion to adjourn will be in order.

PRESIDENT ROGERS: I move we adjourn.

The motion was seconded by several, and the meeting adjourned at ten p. m.

ADJOURNMENT

WEDNESDAY EVENING SESSION
September 21, 1927

The meeting convened at six forty-five p. m., Speaker Doege presiding.

SPEAKER DOEGE: The meeting will please come to order. I will call upon the Secretary for the roll call.

SECRETARY CROWNHART: Mr. Speaker, we have collected twenty-five slips. The rule of the Constitution is that one-fourth of the delegates must be registered in order to be a quorum. I suggest that the registration on these slips constitute the roll of the house.

SPEAKER DOEGE: We will first listen to the report of the Reference Committee on Reports of Officers.

DR. VICTOR F. MARSHALL (Appleton): Your Reference Committee on Reports of Officers begs to report as follows:

We recommend:

1. The adoption of the report of the Chairman of the Council on pages 485 and 486 of the September Journal.

2. The adoption of the report of Dr. Joseph Smith, delegate to the A. M. A., which was made orally and that the stenographic reports of same become a matter of record.

3. Approval of the report of the Secretary as appears upon pages 491 and 492 of the September Journal. This report should be read by every member of the Society and reader of the Journal, and we commend the Secretary for the abundant and magnificent work he has accomplished.

4. Approval of the report of the President, and that it likewise be made a matter of record.

Your committee is in full accord and recommends:

I. The adoption of the recommendations of the Secretary which appear on page 492 of the September Journal:

Your Secretary respectfully suggests the following subject matter to the 1927 House of Delegates.

1. Committees on the study of hospital licensure needs and study of the nursing question are both committees of a special origin. Their work is far from complete despite the time that has been given. Rather than appoint new committees it is suggested that the House authorize the continuance of the present committees until such time as they may submit a final report.

2. The last House of Delegates authorized an appropriation of $650 for the purpose of defraying the expenses of a Secretaries' Conference. This sum provided for the cost of program material and partially covered the rail expenses of secretaries in attendance. It is suggested that this sum be made a continuing appropriation for such annual conferences.

3. For the past two years your Secretary has edited an annual supplement to the Journal containing a digest of all laws affecting the profession. It is now believed that this might be of far greater usefulness if indexed and published as a booklet of convenient desk size. This may be done and a copy furnished each member for $550. A continuing appropriation to this end is suggested.

II. We recommend the approval of the communication from W. C. Woodward, Executive Secretary of the Bureau of Legal Medicine and Legislation of the A. M. A., which appears under the heading "Needed Safeguards in the Promulgation of Regulations under the National Prohibition Act and the Harrison Narcotic Act," which reads as follows:

The imposition of duties and prohibitions on the people through regulations promulgated by department heads, bureau chiefs and administrative boards acting under authority of Congress, and not directly by acts of Congress, seems to be a necessary outcome of the magnitude and complexity of our Government. There is no reason, however, why the formulation and promulgation of such regulations should not be as public as are the deliberations of Congress in the course of the enactment of a statute, nor why such regulations as are promulgated should not be published as widely and made as accessible as are such statutes as are enacted. In fact, publicity, publication, and accessibility are essential to intelligent cooperation between the department head, bureau chief, or board promulgating a regulation and interested members of the community who must live under it, and are necessary to due execution and proper compliance.

Because of the absence of any statutory requirements as to the procedures to be followed with respect to these matters, the practices of various department heads, bureau chiefs, and boards vary, and the practice of a single department head, bureau chief, or board may vary from time to time. It seems desirable, therefore, that the entire situation be regulated by law, so as to promote uniformity and to hinder arbitrary and unwise action.

The same principles should doubtless apply to all regulations having the force and effect of law. Organized medicine, however, can hardly concern itself with such a broad field, but must properly limit its interests to the fields of particular interest to the medical profession, namely, the fields covered by the National Prohibition Act and the Harrison Narcotic Act. With a view to the proper control of the promulgation of regulations under the acts named and under similar acts, the following principles are suggested, for enactment into law:

1. Adequate public notice shall be given, and opportunity afforded interested parties to be heard, by brief or orally, before any regulation is promulgated.

2. Any regulation promulgated shall be officially published so as to inform the interested public of that fact.

3. A reasonable time shall be allowed after the promulgation of any regulation before it becomes effective.

4. Authentic copies of all regulations shall be available at all times to persons requesting them.

5. All regulations promulgated shall be officially reported to Congress annually and be published in authentic form in the Statutes at Large or in some other proper, generally available form.

6. When Congress first convenes after the enactment of the proposed law, all regulations in force shall be officially reported to Congress and shall be published in authentic form in the Statutes at Large in some proper and convenient form so as to bring publication up to date.

7. To meet emergencies, the President may waive the time limits and proceedings normally required for the promulgation of regulations, so as to permit the promulgation immediately of regulations necessary to meet the situation, such regulations to remain in force until regulations can be promulgated in due course.

III. We recommend the establishment of a Foundation Fund for this Society and recommend that a committee of three, which committee is to consist of the President of the Society, the Speaker of the House of Delegates, and the Executive Secretary, they to formulate a plan and to report such plan at the January meeting of the council for their action thereon.

IV. We recommend that a two-day Health Conference be held in Milwaukee, January, 1928, in accordance with the suggestion of Dr. McGovern, President-Elect.

SPEAKER DOEGE: You have heard the report of the Reference Committee on Reports of Officers. What is your pleasure?

DR. POWERS (Milwaukee): I move it be adopted.

The motion was seconded by Dr. Mauermann, of Monroe.

SECRETARY CROWNHART: Mr. Speaker, if I may suggest, if any delegate has any point he wants to express in opposition to the report of the committee, he is perfectly at liberty to do so, by all means, because we are trying to form a policy of the Society which shall represent group opinion.

SPEAKER DOEGE: The motion has been made and seconded to accept this report.

DR. GENTZ PERRY (Kenosha): From personal observation and experience, I feel that those resolutions and the suggestions in there are very timely. I think it is a very wise thing for us to follow that suggested activity.

The motion was carried.

SPEAKER DOEGE: The next is the report of the Reference Committee on Resolutions.

DR. STANLEY SEEGER (Milwaukee): I am on the committee, but the chairman of the committee, Dr. Stang, was to present the resolutions. Apparently he is absent.

SECRETARY CROWNHART: I have a copy of the report. Will you examine it and present it for him if my copy is correct?

DR. SEEGER: "The Committee on Resolutions recommends to the House of Delegates the following:

"That the dues of ten dollars for the State Society remain the same for the coming year.

"That a vote of thanks be extended to Eau Claire and Associated Counties Medical Society and Mr. Arthur Hedquist, of the Eau Claire Chamber of Commerce, for the cordial reception, hospitality, and arrangements which have been made for the Eighty-Sixth Annual Session of the State Medical Society held at Eau Claire September 21, 22, 23, 1927."

DR. LOTZ: I move the adoption of these resolutions.

The motion was seconded by Dr. Joseph Smith, of Wausau, and Dr. Bernard Krueger, of Cudahy, and carried.

SPEAKER DOEGE: Gentlemen, we have with us a distinguished guest who just came into the room. You heard him this afternoon, but I am sure we would be delighted if he would address the House of Delegates for a moment. Dr. Braasch, would you be kind enough to favor us with a few remarks?

DR. WILLIAM F. BRAASCH (Rochester, President of Minnesota State Medical Society): Gentlemen, I really didn't mean to interrupt the proceedings of this Society. I came here to learn and to be inspired, so I can carry back some of this to our own state society. We come from a very rural district up there in the back woods of Minnesota, and we certainly stand appalled at some of the things you have done here. We were inspired enough by your action in the Basic Science Bill, so we passed one of our own the past year. I understand, however, that our work is very crude. You had the public interested to such an extent when it came to legislative action there was nothing to it. We had to sort of crash the gates, as it were.

We had rather a hard time. Owing to our worthy former president, Herman Johnson, the one and original Herman Johnson, we managed to get it through, but it was a hard struggle. I came to see how it is affecting the population of the state as a whole, particularly some of our chiropractic and osteopathic brethren.

I have only one item and that is this: that we not alone passed the Basic Science Bill, but passed a new medical registration act which requires everybody to register every year. The first two years it will cost five dollars. With a 2,000 membership, that means $10,000 in the treasury additional, which we will need to fight quacks, pretenders, and so forth. One thing I would like to know is whether you have any opposition to the Basic Science Bill. The osteopaths have a big slush fund and are out to crack our bill. We would like to know of any prophylactic measures to employ.

Our association, we feel, is very prosperous. We are on the way toward progress, which seems to affect every state association in the country as far as I can see. It is a wonderful thing to see the interest shown by the average medical man in medical economic affairs and to see how the many problems are being solved. I have nothing to offer to you particularly, nothing new. I hope, however, that you will continue to send your delegate to us, as we enjoyed having Dr. Stang with us this year. I hope he will come back next year, or some other representative. We will plan to do the same with you. The Wisconsin idea of sending delegates to the surrounding territory is a good one, and it is going to sort of weld us together. I look to see when we really can properly develop that idea. I would like to see the time when the Northwest could probably stand together closer as a unit, the Central Northwest, as a unit in the House of Delegates of the A. M. A. I think that might be a valuable thing.

Just this evening all I would do would be to extend our greetings from Minnesota, and say to you that we like to cooperate with you in any measure you see fit. If we can help you in any way, we stand ready to do it, and hope we may call on you for help, too. I thank you. (Applause.)

PRESIDENT DOEGE: The next thing will be the report of the Reference Committee on Reports of Standing Committees.

DR. H. O. CASWELL (Fort Atkinson): Our committee had under consideration three important things:

I. *Committee on Public Policy:*

1. This committee commends and congratulates the Committee on Public Policy on the splendid work that has been accomplished during the year of 1927, especially the report on Public Legislation.

2. The committee, being conscious of the repeated efforts necessary to enact legislation, endorses the recommendations of the committee that further legislative action be energetically followed out in securing the passage of the bills enumerated under recommendations No. 1, A, B, and C:

> Your committee makes the following recommendations for the consideration of the house:
>
> 1. That the following bills defeated at the 1927 session be introduced at the session of 1929:
>
> a. A bill substituting a commission of physicians and the judge to determine questions of insanity in place of the lay jury; further, abolishing the present restriction upon the physician's commitment fee of four dollars for examination and ten cents for each mile of travel necessitated.
>
> b. A bill providing that private institutions for the care of the mentally ill be licensed at their option and cost by the Board of Control, who shall inspect such licensed institutions annually.
>
> c. A bill to provide sufficient funds for the purpose of driving from Wisconsin those who would prey upon the unfortunate sick, thus gaining their livelihood by quackery, fraud and deceit.

3. That the committee also confer with the Board of Medical Examiners regarding a bill to regulate itinerant practitioners and introduce satisfactory legislation to abate this nuisance.

II. *Report of Committee on Health and Public Instruction.*

1. The committee believes that great good has been accomplished by this educational work and that the educational campaign is bearing fruit, and recommends the continuance of this work as outlined.

2. The committee has no suggestions to offer either to curtailing or expanding the work as carried on by the committee.

III. *Report on Committee on Nursing.*

1. The committee, after careful study of the work done by this Committee on Nursing Problems, commends the plans outlined and the progress that has been made, but we feel that this problem is so large that great care and study is necessary by this Society before recommending action suggesting legislation on the nursing problem.

2. Also, cooperation with the nursing organizations in the state is desirable; therefore, this committee recommends the adoption of the suggestion offered by the Committee on the Study of the Nursing Problem.

3. That the Committee on the Nursing Problem be continued, as now constituted, and that after further study the definite and detailed report be submitted to this House of Delegates at its next session for action before legislative action be started.

SPEAKER DOEGE: Gentlemen, you have heard the report of the committee. What is your pleasure?

DR. LOTZ: I move it be adopted.

The motion was seconded by Dr. Powers, of Milwaukee, and carried.

SPEAKER DOEGE: We are under the head of new business. I understand Dr. Harper has something to offer. Is he here? Has any one else anything to offer for this evening?

SECRETARY CROWNHART: Mr. Speaker, I have here a copy of Dr. Harper's resolution. I know he intended that it be introduced but has been unavoidably detained. With permission of the House, I will read it as introduced by Dr. Harper.

"WHEREAS, maternal deaths in the United States have been a subject for much discussion in recent years, on account of the increased mortality; and

"WHEREAS, the conditions and factors that may have a bearing upon the fatalities incident to pregnancy are not always well determined; be it

"RESOLVED, by the Wisconsin State Medical Society, in session assembled, that the Wisconsin State Board of Health, through its Bureau of Maternity and Child Hygiene, in cooperation with the Wisconsin State Medical Society, make a detailed and scientific study of all maternity deaths for a period of two or three years to determine as far as possible the underlying factors incident thereto and report the results of such study at a subsequent meeting of the State Medical Society."

Mr. Speaker, this should properly go to the Committee on Resolutions, but it may be acted on by the House tonight if they so desire.

SPEAKER DOEGE: Gentlemen, what is your wish in this respect?

DR. M. R. WILKINSON (Oconomowoc): I move the adoption of the resolution.

The motion was seconded by Dr. G. R. Duer, of Marinette.

DR. CASWELL: It is in the line of cooperating with the State Board of Health, which is doing so much for the physicians of the state of Wisconsin, and I think it is up to us to cooperate to the fullest extent with Dr. Harper in anything he requests.

The motion was carried.

SPEAKER DOEGE: Any other new business?

SECRETARY CROWNHART: At the meeting tomorrow morning the report of the Committee on Nominations will be presented. It does not preclude any nominations from the floor, if the members desire to make them.

SPEAKER DOEGE: Is there any new business? If not, a motion for adjournment will be in order.

DR. POWERS (Milwaukee): I move we adjourn.

The motion was seconded by several, and carried.

The meeting adjourned at seven-fifteen p. m.

ADJOURNMENT

THURSDAY MORNING SESSION

September 22, 1927

The meeting convened at eight-ten a. m., Speaker Doege presiding.

SPEAKER DOEGE: The meeting will please come to order.

SECRETARY CROWNHART: Mr. Speaker, we have collected, through registration slips, the registration of twenty-nine members of the House, which constitutes more than a quorum.

DR. JOSEPH SMITH (Wausau): I move that the roll as compiled by the Secretary constitute the roll of the House.

The motion was seconded by Dr. Lotz, of Milwaukee, and carried.

SPEAKER DOEGE: The first order of business, according to the Secretary, is the report of the Nominating Committee.

SECRETARY CROWNHART: Mr. Speaker, I have the sealed report, which is the first order of business on the morning of the third session, according to the Constitution.

Your Nominating Committee begs to submit the following names:

President-Elect
Dr. Karl W. Doege, Marshfield.

Speaker of the House of Delegates
Dr. A. J. McDowell, Soldiers Grove.

Vice-Speaker of the House of Delegates
Dr. D. L. Dawson, Rice Lake.

Fraternal Delegate from Wisconsin to Minnesota.
Dr. F. E. Butler, Menomonie.

Fraternal delegate from Wisconsin to Iowa
Dr. Wilson Cunningham, of Platteville.

Fraternal delegate from Wisconsin to Illinois
Dr. Stanley J. Seeger, of Milwaukee.

For place of meeting in 1928, Milwaukee.

This is signed by members of the Nominating Committee.

(Vice-Speaker W. T. Lindsay, of Madison, took the chair.)

VICE-SPEAKER LINDSAY: You have heard the report of the committee, gentlemen; what is your pleasure with reference to this report?

DR. R. C. RODECKER (Holcombe): I move its adoption.

The motion was seconded by Dr. Joseph F. Smith, of Wausau, and Dr. W. H. Bayer, of Merrill, and carried.

DR. DOEGE: Mr. Speaker and Gentlemen of the House: When the State Medical Society of Wisconsin elects one of its members for the high office of president-elect, it is a distinction of which he may well be cognizant, and an honor that he will certainly appreciate. In accepting this office, I am fully aware of the high responsibilities that will be mine for the coming term. I am fully aware, and I want you to appreciate that I am con-

scious of the honor that has been given me, and I am sure that I will to the best of my ability aim to live up to the high expectations which you have a right to have in connection with your officers. I realize that I will have to live up to rather high standards. Your past officers, past presidents of the Society, such as Dr. Cunningham, Dr. Joseph F. Smith, Dr. Arthur W. Rogers, and the president for 1928, Dr. John McGovern, certainly have shown a devotion and an ability to the work of a very high degree. It is my aim to live up to that expectation, and I sincerely hope that I shall be able to do so.

I thank you from the bottom of my heart, and assure you of my earnest endeavor in the future.

VICE-SPEAKER LINDSAY: I think we should have a few words from Dr. McDowell, the new speaker of the House of Delegates.

SECRETARY CROWNHART: I want to call your attention to the fact that out of the 133 members of the last legislature Dr. McDowell was the only member from the Society. It is needless to say credit goes to him for what was accomplished in the legislature more than to all others.

DR. McDOWELL: Members of the House of Delegates: This, of course, comes as a surprise to me. I have attempted, in a way, to be of service to the Medical Society. I have always felt that I much preferred to work in the ranks than to be in any official position. I think I have been a member of the State Medical Society for something like twenty-nine years, and I believe, during that time, I have missed attending but one session. I feel there is no part of the work with which I am connected that I enjoy more than the attendance at the state medical meetings. It is true, of course, that I have been a member of the state legislature for the past two sessions, and if I have contributed in any way to the betterment of the medical organization of the state of Wisconsin and the health laws, I feel amply paid for the time and service I have given. I again thank you for this honor, and shall endeavor to serve you to the best of my ability.

(Speaker McDowell took the chair.)

SPEAKER McDOWELL: Under the head of new business, what is your pleasure?

DR. JOSEPH F. SMITH (Wausau): It may be that I came late, but I didn't hear any report from our accredited delegates to the states of Iowa, Illinois, and Michigan. I think the House should know something about whether these men attended these societies and, if so, how they were received and what the reaction on our part has been.

SECRETARY CROWNHART: I think I can answer that, Dr. Smith. Dr. Stang was most cordially received at Minnesota, and Dr. Nott was very cordially received at Illinois, but will submit his report in typewritten form, so that it will be a part of the minutes or an addenda thereto. Through delinquency of your Secretary, Dr. Dearholt didn't reach the Iowa State Medical Society. We didn't discover the date until ten days before the meeting, and the program didn't get to him soon enough to permit the delegate to make the reservation. I think all the delegates have reported, and the experiment, if it may be called such, certainly proved worth while for at least another year. You probably heard the president of the Minnesota State Society state that as a result of Wisconsin's approach in this movement Minnesota will reciprocate, and we hope it will work out that way in every state.

DR. JOSEPH F. SMITH: How about Michigan?

SECRETARY CROWNHART: There was a slip-up in Michigan. We hope we can straighten that out.

SPEAKER McDOWELL: Anything further under the head of new business you will bring up this morning?

DR. W. H. BAYER (Merrill): To continue the subject of these representatives that we send to the other states, it is my impression that the general membership would get more out of the work of these representatives if they were to report before the general meeting instead of the House of Delegates.

SECRETARY CROWNHART: You make that as a motion?

DR. BAYER: No, I just suggested it.

DR. V. F. MARSHALL (Appleton): I think that is to the point. If we are going to send these men to the other societies, obviously if they report to the House of Delegates it would fall short of accomplishing its full purpose. I move that the following year the report of these three men be made a part of the regular program, not to occupy a large part of the time, but a five or ten minute report in a comprehensive way would give us what inspiration they have for us.

The motion was seconded by Dr. Bayer, of Merrill.

SPEAKER McDOWELL: It has been moved and seconded that the members selected to visit the societies of other states surrounding us give a report to the general assembly. Are there any remarks? All those in favor of this motion manifest by saying "Aye"; contrary, "No". It is carried.

Since this is to be the last session of the House of Delegates, is there anything more under the head of new business? If so, you should bring it up at this time.

SECRETARY CROWNHART: Mr. Speaker, before we entertain a motion to adjourn sine die, I wish to call the attention of the members to the fact that under the new Constitution the speaker of the House of Delegates is ex officio a member of the Council, so that this House maintains a continuous representative in the body that executes the policies you formulate. In that way the House is assured that the policies you formulate are going to be carried out in the very best way possible by the Council as it works along through the year.

SPEAKER McDOWELL: If there is nothing further under the head of new business, I will entertain a motion to adjourn sine die.

DR. R. W. BLUMENTHAL (Milwaukee): I move we adjourn, subject to the call of the President.

The motion was seconded by Dr. Mauermann, of Monroe, and carried.

The meeting adjourned at eight-thirty a. m.

ADJOURNMENT

Action of the Council, Annual Meeting Sessions, September 20-23, 1927

FIRST MEETING

Eau Claire Hotel, Sept. 20, 1927

Roll call: Present, Chairman Evans, La Crosse; President A. W. Rogers, Oconomowoc; Treasurer Rock Sleyster, Wauwatosa; President-Elect John J. McGovern, Milwaukee; Speaker Karl W. Doege, Marshfield; Councilors, G. Windesheim, Kenosha; C. A. Harper, Madison; Wilson Cunningham, Platteville; F. Gregory Connell, Oshkosh; T. J. Redelings, Marinette; Joseph F. Smith, Wausau; H. M. Stang, Eau Claire; John M. Dodd, Ashland; Hoyt E. Dearholt, Milwaukee; Secretary Crownhart and Treasurer-Emeritus S. S. Hall, Minneapolis.

1. It was moved by Dr. Connell, seconded by Dr. Stang, that the minutes of the last meeting as published in the January issue of the Journal be approved as printed. Motion carried.

2. It was moved by Dr. Dodd, seconded by Dr. Rogers, that the Council confirm its mail vote approving of the distribution of periodic health examination pamphlets as submitted by the State Board of Health. Motion carried.

3. It was moved by Dr. Rogers, seconded by Dr. Connell, that the Council approve its mail vote approving the action of the board of trustees of the American Medical Association suggesting federal legislation that will lead to the promulgation of federal regulations under the National Prohibition and Harrison Narcotic acts only after publication and public hearing of the regulations proposed. Motion carried.

4. It was moved by Dr. Connell, seconded by Dr. Dodd, that the Council approve its mail ballot unanimously electing to honorary membership in the State Medical Society of Wisconsin, Dr. L. H. Pelton of Waupaca, a former president of the Society. Motion carried.

5. The Secretary presented to the Council certain correspondence from the secretary of the Michigan State Medical Society relating to the acceptance of a fraternal delegate. It was moved by Dr. Connell, seconded by Dr. Stang and Dr. Cunningham, that pending advice that a fraternal delegate will be acceptable, the Wisconsin delegates be limited to the states of Illinois, Minnesota and Iowa. Motion carried.

6. President-Elect McGovern submitted to the Council a proposal for a conference of official and non-official public health agencies to be held at the headquarters of the State Medical Society. Discussion followed by Drs. Sleyster, Rogers, Cunningham, Dodd, Dearholt, Evans, and Stang. It was moved by Dr. Cunningham, seconded by Dr. Rogers, that the proposal be referred to the House of Delegates with the approval of the Council with minor modifications accepted by President-Elect McGovern. Motion carried.

7. President-Elect McGovern submitted to the Council a proposal in the field of encouragement of periodic health examinations. A round table discussion followed. It was moved by Dr. Cunningham, seconded by Dr. Stang, that the Chairman of the Council appoint a committee of two who, with the President-Elect, should investigate the feasibility of the plan and ascertain whether or not legal liability would be envolved and whether such a plan would meet with the approval of the executive heads of the American Medical Association; the committee to report to the January meeting of the Council. Motion carried.

8. The Secretary called the attention of the Council to the prevalence of the so-called industrial vision survey suggesting that this matter might well be presented in the Journal. It was moved by Dr. Smith, seconded by Dr. Connell, that the Secretary gather all available information and report a series of articles for approval of the Council at the January meeting. Motion carried.

9. The Secretary called attention to the fact that the Society had no fire insurance on the contents of its offices. It was moved by Dr. Rogers, seconded by Dr. Dodd, that the Treasurer be instructed to secure such insurance in such amount as deemed wise. Motion carried.

10. The Secretary suggested the following salary increases: Miss Astrid Jurgens from $165 to $170 and Miss Florence Ripley from $117 to $120 a month. Moved by Dr. Rogers, seconded by Dr. Dodd that the increases become effective with the October payroll. Motion carried.

11. The Secretary read a communication from the Waukesha County Medical Society suggesting that Dr. Margaret Caldwell, Waukesha, the oldest woman physician in Wisconsin, be elected an honorary member of the State Medical Society of Wisconsin. Moved by Dr. Cunningham, seconded by Dr. Redelings, that Dr. Caldwell be elected to honorary membership. Motion carried.

12. Dr. Rock Sleyster suggested to the Council the advisability of the Society paying tribute to the memory of the late Dr. J. V. R. Lyman. It was moved by Dr. Dodd, seconded by Dr. Connell, that the Chairman appoint a committee to arrange for the laying of a wreath upon Dr. Lyman's grave following the scientific session on Thursday afternoon. Motion carried.

Chairman Evans announced the appointment of Drs. Stang, Sleyster and Dodd to constitute the necessary committee.

There being no further business, the Council adjourned at 6:15 p. m.

J. G. Crownhart, *Secretary.*

Approved: Edward Evans, *Chairman of the Council.*

SECOND MEETING

Eau Claire Hotel, Wednesday, Sept. 22, 1927

Roll call: Present, Chairman Evans, La Crosse; President A. W. Rogers, Oconomowoc; President-Elect J. J. McGovern, Milwaukee; Speaker of the House K. W. Doege, Marshfield; Treasurer Rock Sleyster, Wauwatosa; Treasurer Emeritus S. S. Hall, Minneapolis; Councilors R. W. Blumenthal, Milwaukee; F. Gregory Connell, Oshkosh; Wilson Cunningham, Platteville; John M. Dodd, Ashland; Joseph F. Smith, Wausau, and T. J. Redelings, Marinette; Secretary Crownhart and the following guests: H. E. Dearholt and Oscar Lotz of the Editorial Board and S. J. Seeger, Trustee of the Milwaukee County Medical Society.

1. Chairman Evans announced that at the previous session a committee had been authorized to work with President-Elect McGovern on a plan for extending periodic health examinations. He then appointed on the committee Drs. H. E. Dearholt of the Editorial Board and R. W. Blumenthal of the Council.

2. There being no further business, the Council adjourned. J. G. CROWNHART, *Secretary.*

Approved: EDWARD EVANS, *Chairman of the Council.*

THIRD MEETING

Fournier's Academy, Thursday, Sept. 23, 1927

Roll call: Present, President A. W. Rogers, Oconomowoc; Treasurer Rock Sleyster, Wauwatosa; President-Elect J. J. McGovern, Milwaukee, and K. W. Doege, Marshfield. Councilors Joseph F. Smith, Wausau; Robert W. Blumenthal, Milwaukee; T. J. Redelings, Marinette; Wilson Cunningham, Platteville, and H. M. Stang, Eau Claire, and the Secretary. In the absence of the Chairman, Dr. Evans, the President, was called to the chair.

1. The Secretary stated that a few minutes after the House of Delegates had adjourned *sine die* Mrs. H. M. Stang brought to the Secretary a message and resolution from Dr. H. M. Stang. There being no further opportunity to assemble a quorum of the House, Dr. Stang and the Secretary agreed that it would be well to present the matter at this Council meeting.

Dr. Stang then stated that as Chairman of the Committee on Resolutions of the House he had received from the La Crosse County Medical Society a proposed resolution; that due to his absence from the House both Wednesday night and Thursday morning he had not presented the resolution but now desired to present it to the Council. The resolution was read as follows:

"Whereas, our Medical Practice Act has been amended by the recent legislature which elevates the standards of our medical profession and enhances the requirements for licensures, and

"Whereas, a program of law enforcement has been undertaken that has been gratifying to the profession and of immeasurable value to the general public; therefore,

"Be It Resolved, that our State Medical Society in executive session extend to the State Board of Medical Examiners this expression of appreciation for their splendid services and especially do we commend their executive officer, Dr. Robert E. Flynn, for his untiring zeal in conducting these activities and for the prompt and courteous manner in which he fulfilled the duties of his office.

"Be It Further Resolved, that a copy of this resolution be presented to the State Board of Medical Examiners and a copy ordered printed in our Wisconsin Medical Journal.

"LA CROSSE COUNTY MEDICAL SOCIETY,
E. SMEDAL, *President,*
N. P. ANDERSON, *Secretary.*"

A general discussion ensued during which it was pointed out that the House of Delegates had already endorsed the work of the Board as a whole and that the sole addition by this resolution was to specifically endorse the work of its Secretary. After extended discussion, all participating except the Secretary, it was moved by Dr. Wilson Cunningham, Platteville, seconded by Dr. Robert Blumenthal, Milwaukee, that the resolution be rejected in view of the action already taken by the House and the fact that it was the declared policy of the Society not to endorse anything of a political or quasi-political nature. Motion unanimously carried.

2. The Secretary announced receipt of a copy of an opinion from the Attorney General of Wisconsin to Dr. R. E. Flynn, Secretary of the Board of Medical Examiners. Dr. Flynn had asked the Attorney General whether it was not legal for the State Medical Society to make a donation or loan to finance the law enforcement efforts of the Board. The Attorney General declared that it was both illegal for the Board to solicit or receive monies from the State Medical Society of Wisconsin, concurring in the action taken by the Council at the last annual meeting and at the January, 1927, meeting.

3. A general discussion was had as to the welfare of the Society. The Secretary was directed to prepare and submit to the Editorial Board of the Journal an article dealing with the matters under discussion to be used as occasion might require in the future. It was further unanimously agreed that President Rogers, President-Elect McGovern and Speaker Doege and the Secretary be empowered to take such other action as to them seemed wise to carry out the Council's views and best to serve the Society interest.

4. Meeting adjourned at 5:15.

J. G. CROWNHART, *Secretary.*

Approved: A. W. ROGERS, *President,*
Acting Chairman of the Meeting.

Dr. Louis F. Jermain, Dean Emeritus of Marquette University School of Medicine, Honored

Bestowing upon Dr. Louis F. Jermain of Milwaukee a golden key commemorating his years of service with the Marquette University School of Medicine, faculty and students of Marquette gathered recently in Milwaukee for a special testimonial dinner. The address of the evening was made by Dr. Eben J. Carey, director of the Department of Anatomy and Acting Dean of the school. The address follows:

Dr. Jermain: It is an honor, as well as pleasure for me, to present to you a token from the Trustees, Faculty and Students of the Schools of Medicine and Nursing of Marquette University, symbolizing our gratitude for your guiding leadership, creative spirit, and labor of love as Dean of the Medical School for thirteen years, from 1913 to 1926. It was a worthy ambition to establish and foster a complete five-year Class A Medical

This Gold Key was presented to Dean Emeritus Louis F. Jermain from the Trustees, Faculty and Students of the Marquette University Schools of Medicine and Nursing, in grateful recognition of his services as Dean of the Medical School from 1913 to 1926.

School, with an endowment of over $2,000,000, the first in the State of Wisconsin. Your work had disclosed a spirit of exploration and a spirit of service for medical education. I may well exclaim with Whitman, "Pioneer! O Pioneer!" Your loss of consciousness of self, your constructive impulses, flow with emotional warmth to achieve for others, to relieve human suffering and to prolong life.

In the course of human events it is well that the younger generation stops to honor achievement and eminence, the more so when youth is the direct recipient of the blessings bestowed by their elders. Progress is dependent on imagination. Imagination is dependent on the past. A worthy past is a benevolent atmosphere for new growth. To you, Dr. Jermain, we express, as beneficiaries, a deep heartfelt gratitude for creating a medical background, our heritage, that has been passed to us as a dower at Marquette University.

Your adventure in medical education teaches us that men will find what is sufficient to their needs only when they seek. Your fearless constant inquiry, your quest for truth, is an example of irresistible curiosity that typifies the ideal clinical teacher and scientific investigator. You have sought and found. Tonight you witness before you an event of history at Marquette University School of Medicine, a testimonial of 383 faculty members and students. There is present the largest and one of the best prepared Freshman classes ever to enter the Medical School. This class, however, is a direct challenge to your successors for more achievement, for more endowment, for more hospital facilities.

This event typifies your pursuit of an ideal and an approximate consummation of that ideal. You have induced in us *enthusiasm* to maintain high the torch of medical education; to show *cheerful sympathy* with all who struggle and take time out to cheer others on the way of accomplishment, and to manifest *humility*. By your subconscious glimpses of an ideal you realized no work is perfect and that constant vigilance and effort is the price of realizing anything worth while.

According to Osler—

"The man of medical science and art is great only to the extent of his devotion not simply to medical truth, but to other men."

When one reflects, it is not difficult to see, moreover, why such a man as Pasteur, the great scientific forerunner of this spirit of service to humanity, should be also a man with a conception of the infinite, which enabled him to see all things clearly and in fair proportion. This man, who has been called "the most perfect man who had ever entered the Kingdom of Science" and who gave his genius humbly to those who had to bear the heat and isolation of countless wearisome days, in order to save their silkworms, to save their sheep, to save their children from hydrophobia, this man Pasteur, with all this scientific achievement, also wrote the following:

"Positivism does not take into account the most important of positive notions, that of the Infinite. I see everywhere the inevitable expression of the Infinite in the world—the ideal of God in a form of the idea of the Infinite. Blessed is he who carries within himself a God, an ideal, and who obeys it; ideal of art, ideal of science, ideal of gospel virtues, therein lie the springs of great thoughts and great actions; they all reflect light from Infinite Love."

By your precept and example, Dr. Jermain, we

have learned that there are three principal actions of human life:

(1) Force—Power between physical bodies.
(2) Thought—Power of human mind.
(3) Charity—Power of the heart.

Emotional warmth and sympathy precede thought or judgment in the mind of the true pioneer. The dominant order of these three principles in the world is force—thought—charity. Your life teaches us that charity comes first. It is this quality that leads to the annihilation of self and engenders in us a spirit of service to others. Consequently this honor key, designed by Leo Massopust of the Medical School, and which the committee has interpreted typifies three spirits:

The seal of Marquette University superimposed upon the Caduceus and beneath this seal a diamond, are symbolic, first, of the restless spirit of the seeker, the pioneer, the explorer, the discoverer, by Pere Marquette in a canoe, the discoverer of the Mississippi River; second, the spirit of service to humanity by the Caduceus. These two spirits are realized by the third one symbolized by the diamond, the radiant light of love.

Every man has this spirit of love engendered by some good woman, who teaches us each day from sunrise to sunset something of life. In the feeble light of dawn you see yourself as a helpless infant in the arms of your mother. Hour by hour as year by year goes on, and then the youth. Time goes on and then the mid-day manhood bursts upon you. The zenith of life, a time when the nobleness of the soul opens to the world in all its grandeur, to shed its radiance and warmth around it, brightening and cheering the darkened pathways its fellows are treading. It is then that another good woman, Mrs. Jermain, brightened and cheered your pathway and blessed you with honorable heirs. She helped you to grapple with life, measure it and fill it with a purpose. None could do more. Your kind words and deeds for your unfortunate fellow man has been your purpose in life. When the sun is fast declining and the evening of life is upon you and Mrs. Jermain, may you both sit in the twilight and look back on the billows of noble thought and deeds of Christian charity, which roll from the sea of shadowy memory, bearing to you sweet messages of a well spent life and the loving words of the trustees, faculty and students of the Marquette University of Medicine and Nursing.

"Well done, good and faithful servant."

Basic Science Board

Twelve additional candidates passed the Wisconsin Basic Science Board examination held on September 17 according to Prof. M. F. Guyer, secretary of the board. Successful candidates are: Bachhuber, Alphons E. Jr, Bachhuber, Harold A., Banfield, S. R., Benn, Hubert P., Hardgrove, Maurier A. F., Henry, Merlyn George, Hitz, John B., Korfmacher, Edwin S., McAndrews, Leo F., Robbins, J. Holden, Stuessy, Milton F., and Zimmerman, Felix Herman.

The questions of the examination follow:

HUMAN ANATOMY

1. Locate with anatomical accuracy the following structures:

(a) Palatine tonsil.
(b) Urinary bladder.
(c) Prostrate gland.
(d) Vermiform appendix.
(e) Gall bladder.
(f) Stomach.
(g) Right kidney.
(h) Thyroid gland.
(i) Pancreas.
(j) Mid-brain.

2. Describe the gross and microscopic structure of a skeleton muscle, using the biceps of the arm as an example. Include a clear account of the anatomical and functional relation of other structures to it, and of it as an organ to the rest of the body, the arm in particular.

3. Point out at least five important anatomical differences between a child of about five years and an adult of about thirty.

4. Make out two questions for a Basic Science Board examination in anatomy of the sort which you think would test fairly a man's knowledge of some of the fundamentals of anatomy necessary for intelligent practice of the healing art.

PHYSIOLOGY

1. Give the quantitative composition of the blood and name the functions of the different elements found in the blood stream. To what is each heart sound due?

2. Describe the nervous and the hormone control of respiration.

3. Give a physiological comparison between

smooth and striated muscle, and tell how the characteristics of each are adapted to its functions.

4. Describe the control of pancreatic secretion.
5. Define:

Basal metabolism.
Osmosis.
Reflex.
Zymogen.
Protein.

PATHOLOGY

1. Discuss pathological fatty changes.
2. Describe, briefly, the various types of splenomegaly.
3. Describe the histogenesis, microscopic anatomy, course and possible terminations of the typical lesion of tuberculosis.
4. Discuss endothelioinomata.
5. Discuss the so-called primary contracted or small red kidney.
6. Dilscuss the general etiology of tumors.
7. What is pachmeningitis hemorrhagica internal?
8. Discuss ulceration of the lip.

DIAGNOSIS

In five of the following:

(a) Establish the diagnostic significance by stating conditions indicated;

(b) On what additional symptoms, history and physical or laboratory findings may one depend to make each indicated diagnosis clear?

1. Coma.
2. Sharp pain in right side of chest.
3. Gross swelling of both ankles.
4. Paroxysmal coughing.
5. Enlargement of neck anterior to cleidomastoid muscles.
6. Acute epigastric pain.
7. Bleeding from rectum.

Discuss only five of the above.

STATE DUES

Thirteen states now have dues of $10.00 or more and twelve states have an annual budget of $20,000 or more, according to a compilation made recently. The dues and totals received follow:

Society	*Dues*	*Total Received*
District of Columbia	$20.00	$ 11,000
Arizona	15.00	3,000
Minnesota	15.00	30,000
California	10.00	43,000
Florida	10.00	10,000
New York	10.00	111,000
Michigan	10.00	30,000
New Jersey	10.00	23,000
Rhode Island	10.00	4,000
Texas	10.00	36,000
Vermont	10.00	3,700
West Virginia	10.00	11,000
Wisconsin	10.00	20,000
Illinois	8.00	58,000
Missouri	8.00	26,000
Nebraska	8.00	3,000
Massachusetts	8.00	35,000
Indiana	7.00	19,000
Nevada	7.00	600
Idaho	6.00	1,000
Colorado	5.00	6,000
Delaware	5.00	800
Georgia	5.00	8,000
Kansas	5.00	8,000
Kentucky	5.00	10,000
Montana	5.00	2,000
New Mexico	5.00	1,000
North Dakota	5.00	2,000
Ohio	5.00	26,000
Pennsylvania	5.00	38,000
South Dakota	5.00	2,000
Utah	5.00	2,000
Virginia	5.00	9,000
Washington	5.00	6,000
Connecticut	4.00	5,000
Louisiana	4.00	5,000
Maine	4.00	3,000
New Hampshire	4.00	2,000
Oklahoma	4.00	7,000
Tennessee	4.00	6,000
Alabama	3.00	5,000
Arkansas	3.00	4,000
Mississippi	3.00	3,000
North Carolina	3.00	5,000

PROHIBITION REGULATIONS ANNOUNCED.

Official announcement of the changes made in the old Regulations 60, now known as Regulations 2, governing the withdrawal and prescribing of intoxicating liquors, has been released by the Federal Prohibition Bureau. The new regulations contain five important changes, one of which affects physicians holding permits to prescribe or use such liquors.

This change, as announced, follows:

"Further restrictions are made on prescriptions of liquor for medicinal purposes by a new provision that a prescription for liquor must be filled within three days after it is issued unless the physician extends the time for not exceeding an additional three days, and a new requirement that compounded prescriptions in which potable distilled spirits are used may not be written or filled for a gross quantity in excess of six fluid ounces."

THE JOURNAL BOOK SHELF

A Textbook of Clinical Neurology. By Israel S. Wechsler, M. D., Assistant Prof. of Clinical Neurology, Columbia University, New York; Attending Neurologist, The Montefiore Hospital, New York. Octavo volume of 725 pages with 127 illustrations. Cloth, $7.00. W. B. Saunders Company, Philadelphia and London.

Collected Papers of the Mayo Clinic and the Mayo Foundation, 1926, Rochester, Minnesota. Octavo of 1329 pages, with 386 illustrations. Cloth, $13.00 net. W. B. Saunders Company, Philadelphia and London, 1927.

Medical Clinics of North America. Vol. X, No. 6, Heart number, May, 1927. Octavo of 211 pages with 101 illustrations and complete index to Vol. X. Per clinic year, July, 1926, to May, 1927. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

Lippincott's Pocket Formulary. By George E. Rehberger, M. D., author of Lippincott's Quick Reference Book. This little pocket therapeutics has been prepared to provide the practitioner with a conveniently sized ready reference manual. Price, $3.50. J. B. Lippincott Company, Philadelphia.

The Human Body in Pictures. By Jacob Sarnoff, M. D., Associate Surgeon, United Israel-Zion Hospital, Brooklyn. A visual text of Anatomy, Physiology and Embryology. Price, $2.00. Physician & Surgeons Book Co., Brooklyn, N. Y.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared original articles. By leading members of the medical profession throughout the world. Vol. II, 37th series, 1927. J. B. Lippincott Company, Philadelphia and London.

Diseases of the Skin. A practical treatise for the use of students and practitioners. By Oliver S. Ormsby, M. D., Clinical Professor and Chairman of the Department of Dermatology, Rush Medical College of the University of Chicago. Third edition, thoroughly revised. Illustrated with 521 engravings and 3 colored plates. Price, $11.00. Lea & Febiger, Philadelphia, 1927.

Manual of the Diseases of the Eye. For students and general practitioners. By Charles H. May, M. D., Director and Visiting Surgeon, Eye Service, Belleview Hospital, New York, 1916 to 1926; Instructor in Ophthalmology, College of Physicians and Surgeons, Columbia University, New York. Twelfth edition, revised, with 374 original illustrations, including 23 plates, with 73 colored figures. Price, $4.00. William Wood & Company, New York, 1927.

Nineteenth Report of The Henry Phipps Institute, University of Pennsylvania. For the study, treatment and prevention of tuberculosis. Henry Phipps Institute, Seventh and Lombard Sts., Philadelphia, 1927.

A Text Book on Pathology. By Alfred Stengel, M. D., Professor of Medicine, University of Pennsylvania, and Herbert Fox, M. D., Professor of Comparative Pathology, and Director of the Pepper Laboratory of Clinical Medicine, University of Pennsylvania. Eighth edition, reset. Octavo of 1138 pages with 552 text illustrations, many in colors, and 18 colored plates. Cloth, $10.00 net. W. B. Saunders Company, Philadelphia and London, 1927.

Heart and Athletics. Clinical researches upon the influence of athletics upon the heart. By Dr. Felix Deutsch, Privatdocent in Internal Medicine at the University of Vienna, and Dr. Emil Kauf, Assistant at the "Heart Station" in Vienna. English translation by Louis M. Warfield, M. D., former Professor of Internal Medicine, University of Michigan. Price, $2.50. C. V. Mosby Company, St. Louis, 1927.

Textbook on Diseases of the Skin and Syphilis. Designed for the use of students and practitioners. Albert Strickler, M. D., Professor of Dermatology and Syphilology, Temple University, Department of Medicine. Cloth. Price, $8.00, pp. 689, with 218 illustrations. Philadelphia, F. A. Davis Company, 1927.

BOOKS RECEIVED FOR REVIEW

Surgical Diseases of the Gall-Bladder, Liver and Pancreas and Their Treatment. By Moses Behrend, M. D., Attending Surgeon to the Hebrew Orphans Home and Instructor in Anatomy in the Jefferson Medical College. With numerous illustrations, some in colors, including many full page plates. Price $4.00 net. F. A. Davis Company, Philadelphia, 1927.

Feeding and the Nutritional Disorders in Infancy and Childhood. By Julius H. Hess, M. D., Professor and Head of the Department of Pediatrics, University of Illinois College of Medicine; Attending Pediatrician to Cook County, Michael Reese and Englewood Hospitals, Chicago. Illustrated with forty-five engravings in the text and one full-page colored plate. Fifth revised and enlarged edition. Price $4.50 net. F. A. Davis Company, Philadelphia, 1927.

Fistula of the Anus and Rectum. By Charles John Drueck, M. D., Professor of Rectal Diseases, Post Graduate Hospital and Medical School, Chicago. With sixty-six original illustrations. Price $3.50 net. F. A. Davis Company, Philadelphia, 1927.

Cancer Control. Report of an international symposium held under the auspices of the American Society for the Control of Cancer. Lake Mohonk, New York, September 20-24, 1926. The Surgical Publishing Co., Chicago, 1927.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared original articles by leading members of the medical profession throughout the world. Vol. III, thirty-seventh series. J. B. Lippincott Company, Philadelphia and London, 1927.

Minor Surgery. By Arthur E. Hertzler, M. D., Chief Surgeon, Halstead Hospital, and Victor E. Chesky, M. D., Chief Resident Surgeon, Halstead Hospital. With 438 illustrations. Price $10.00. C. V. Mosby Co., St. Louis, 1927.

Emergencies of a General Practice. By the late Nathan Clark Morse, M. D., revised and rewritten by Amos Watson Colcord, M. D. Second edition. Price $10.00. C. V. Mosby Co., St. Louis, 1927.

Gonococcal Infection in the Male. By Abr. L. Wolbarst, M. D., Urologist and Director of Urologic Clinics, Beth Israel Hospital, New York. With eighty-nine illustrations, including seven color plates. Price $5.50. C. V. Mosby Co., St. Louis, 1927.

Clinical Case-Taking. Supplement to Methods in Medicine. By George R. Herrmann, M. D., Assistant Professor of Medicine, Tulane University, New Orleans. Price $1.50. C. V. Mosby Co., St. Louis, 1927.

Getting Well and Staying Well. A book for tuberculous patients, public health nurses, and doctors. By John Potts, M. D., Fort Worth, Tex. Price $2.00. C. V. Mosby Co., St. Louis, 1927.

Physical Diagnosis. By Richard C. Cabot, M. D., Professor of Medicine in Harvard University. Ninth Edition.

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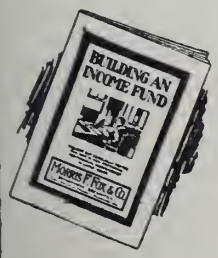

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Revised and enlarged with six plates and 279 figures in the text. William Wood & Co., New York, 1927.

Cultivating the Child's Appetite. By Charles Anderson Aldrich, M. D., Associate Attending Physician, Children's Memorial Hospital, Chicago. The Macmillan Company, New York, 1927.

Blood-Pressure, Its Clinical Applications. By George William Norris, M. D., Professor of Clinical Medicine in the University of Pennsylvania, Henry Cuthbert Bazett, M. B., Professor of Physiology in the University of Pennsylvania, and Thomas M. McMillan, M. D., Assistant Physician to the Pennsylvania Hospital, Philadelphia. Fourth edition, thoroughly revised; illustrated with 47 engravings and 1 colored plate. Price $4.50. Lea & Febiger, Philadelphia, 1927.

The Ophthalmic Year Book. Volume XXIII, containing bibliographies, digests, and indexes of the literature of ophthalmology for the year 1926. Published by the Ophthalmic Publishing Company, Chicago.

Affections of the Stomach. By Burrill B. Crohn, M. D., Associate Attending Physician to the Mt. Sinai Hospital, New York City. Octavo of 902 pages with 361 illustrations, some in colors. Price $10.00. W. B. Saunders Company, Philadelphia and London.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 153 E. Wells Street, Milwaukee, Wisconsin. These new books will be loaned for an inspection period only.

Surgical Clinics of North America. Vol. VII, No. 3, Chicago number, June, 1927. Pages, 330, with 81 illustrations. Per clinic year, February, 1927, to December, 1927. Paper, $12.00; cloth, $16.00. W. B. Saunders Co., Philadelphia and London.

The Chicago number of this series contains clinical contributions from Presbyterian, Evanston, Wesley Memorial, Cook County, Chicago Lying-In, Michael Reese, St. Luke's, Washington Boulevard and South Shore Hospitals, the Urological Departments of Rush Medical College and Northwestern University Medical School and the Research and Educational Hospital of University of Illinois.

The authors contribute a great variety of material including cases illustrating problems involved in surgery of the brain and nervous system, general abdominal surgery, plastic surgery, orthopedic surgery, gynecology, and orthopedics.

McWhorter reports an interesting series of five cases of spastic colitis simulating acute appendicitis, which is probably one type of so-called intestinal influenza.—S. J. S.

Potassium and Tartrates. A review of the literature on their physiological effects. By Ralph W. Webster, M. D., Prof. of Medical Jurisprudence in University of Chicago. The Commonwealth Press, Inc., 1112 South Wabash Ave., Chicago.

This small book is merely a compend of abstracts with a short introductory on the effects of potassium and the tartrates upon important organs. It is of interest to chemists particularly.—L. M. W.

Text Book of Bacteriology. By William W. Ford, M. D., Professor of Bacteriology, School of Hygiene and Public Health; Lecturer on Hygiene, School of Medicine, Johns Hopkins University. Octavo of 1,069 pages with 186 illustrations. Cloth, $8.50 net. W. B. Saunders Company, Philadelphia and London, 1927.

A complete up-to-date book on medical bacteriology. Everything that is required by the student and practitioner is contained in this volume. The references are numerous.

The grouping and arrangement is convenient and orderly. Part I is devoted to general bacteriology, with technique, numerous staining methods, and a very good chapter on disinfectants. In Part II there is a systematic description of organisms with good illustrations. Part III is devoted to the distribution of bacteria. The chapters on infection and immunity are complete. There is a short chapter on the bacteriophage. Part V is set aside for the discussion of spirochaetes. Diseases of infectious agents of undetermined character are considered in Part VI.

More than is contained in this volume could not be expected of a book on bacteriology.—E. L. T.

Medical Clinics of North America. Vol. II. No. 1, Chicago number, July, 1927. Octavo of 294 pages with 26 illustrations. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

This well known publication comes to hand again. It is up to its usual standard and contains a number of interesting clinical articles, especially one on fusospirochetal pulmonary abscess. Both pellegra and amebic dysentery are found in this volume.

This will be interesting to the profession of the south.—L. M. W.

Feeding and the Nutritional Disorders in Infancy and Childhood. By Julius H. Hess, M. D., Professor and Head of the Department of Pediatrics, University of Illinois College of Medicine; Attending Pediatrician to Cook County, Michael Reese and Englewood Hospitals, Chicago. Illustrated with forty-five engravings in the text and one full-page colored plate. Fifth revised and enlarged edition. Price $4.50 net. F. A. Davis Company, Philadelphia, 1927.

The fifth edition of this well known manual is strictly modern and up to date. It contains the latest views and theories on the practice of infant feeding. The methods advocated and advised are simple and easily understood. They consist chiefly in the use of whole milk mixtures (1½ ounces per pound of body weight) with the addition of carbohydrate (1/10 of an ounce per pound body weight) and enough water to supply two to three ounces of fluid per pound each day. For the use of those physicians who desire to feed infants with other kinds of food, a full description is given of lactic acid, orange and lemon juice, dried milk, top milk and other formulae. A very full consideration is given to breast feeding and the feeding of premature infants. There are chapters on rickets, scurvy, spasmophilia, acidosis and alkalosis, coeliac disease and anemias of infancy. The chapters on physiology and metabolism are inadequate, but other volumes may be consulted by those who wish a fuller description of these subjects. Dr. Hess's book is emphatically practical and will undoubtedly be a valuable addition to the medical library.—R. M. G.

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DIAGNOSTIC PROBLEMS

(Continued from Page 559)

where it was somewhat nodular and extended down into the false pelvis to the right of the midline. The liver was enlarged and doughy in consistency with a sharp lower border at the level of the navel. Inguinal lymphatics were not felt and there was no ascites made out. It was also learned that 14 years ago he was operated on for hemorrhoids and that he had had a hernia operation 2 years ago. He was in the hospital for 11 days and during that time he had slight irregular fever, never above 101. He became gradually weaker. On the 16th of August he had a violent hemorrhage from his stomach and shortly afterwards died.

The laboratory findings were as follows: X-ray of the lungs revealed on both sides infiltration of the apices with fine snowflake infiltration from the clavicle to the base, in the outer and middle zones. The cardiac shadow was normal. There were no mediastinal masses. A blood count made on the 6th showed hemoglobin 100%, reds 4,600,000, whites 11,950. Differential count showed polys 84%, myelocyctes 11%, eosinophile polys 2%, large mononuclear cells 2%. There was some variation in the size and shape of the red cells. The Wassermann reaction was negative. There was no change in the fragility of the red cells, icterus index 15. 1. There was some increase in the non-protein nitrogen of the blood with a normal cholesterol.

The following is an abstract of the important autopsy findings: Marked anthracosis with chronic adhesive pleurisy of both lungs. The peritoneal cavity was free from fluid, surface was smooth and glistening. The spleen weighed 2,160 gr., measured 28x19x7½ cm. The surface was something like a mosaic of dark brownish red, in which were interspersed irregular areas of creamy yellow color from 3 mm. up to 3 or 4 cm. in size. The whole organ was firm and the yellow areas were especially firm. On section the mottled appearance was found throughout the organ. These areas were sharply marked out from the spleen tissue. The liver was normal in size, showed only cloudy swelling and congestion. All the lymph nodes in the abdominal cavity were much enlarged, pinkish in color and very cellular and edematous when cut. The kidneys showed the gross lesions of an arteriosclerotic nature. There was a duodenal ulcer which had extended through the duodenum and whose base was the retro-peritoneal tissue against the pancreas completely walled off from the peritoneal cavity.

THERAPEUTIC NOTES

New and Nonofficial Remedies

In addition to the articles enumerated previously the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

E. Bilhuber, Inc.

Bromural.

Parke, Davis & Co.

Diphtheria Toxin-Antitoxin, 0.1 L+.—P. D. & Co.

Swan Myers Co.

Capsules Ephedrine Hydrochloride.—Swan-Myers, 0.05 Gm.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

Acetarsone—Abbott.—A brand of acetarsone—N. N. R. For a discussion of the actions, uses and dosage of acetarsone, see New and Nonofficial Remedies, 1927, p. 83. This product is supplied in substance and in 0.25 Gm. tablets. Abbott Laboratories, North Chicago.

Erysipelas Streptococcus Antitoxin (Concentrated) Mulford.—An erysipelas streptococcus antitoxin (New and Nonofficial Remedies, 1927, p. 337) prepared by injecting horses intradermally with strains of hemolytic streptococci isolated by H. Amoss from human cases of erysipelas lesions, bleeding the horses and when test bleedings show the serum to have reached the desired potency, separating the serum, sterilizing it, and preserving by the addition of 0.35 per cent of phenol. The product is then concentrated by a process which preserves both the antitoxic and antibacterial properties claimed to be in the original serum. The product is marketed in packages of one 20 cc. syringe. H. K. Mulford Co., Philadelphia.

Cholera Bacterin (Cholera Vaccine).—This cholera vaccine (New and Nonofficial Remedies, 1927, p. 358) is also marketed in packages of one 20 cc. vial containing 1,000 million killed cholera vibrios per cc. H. K. Mulford Co., Philadelphia. (Jour. A. M. A., September 10, 1927, p. 883.)

Iodoxybenzoates.—Iodoxybenzoic acid resembles salicylic acid, chemically differing in that the hydroxyl group of the latter has been replaced by an iodoxy group. The known actions of the salts of iodoxybenzoic acid, as developed by investigators, led up to its clinical application by Young and Youmans in the treatment of arthritis. The investigators, in their introduction of the substance, used the sodium salt or ammonium salt prepared extemporaneously; later, they recommended the use of ammonium iodoxybenzoate. The salts of iodoxybenzoic acid are indicated chiefly in arthritis. They are reported to be preferably administered intravenously; however, for cases in which the drug cannot be given intravenously, oral administration and administration by high enema have been employed and found effective.

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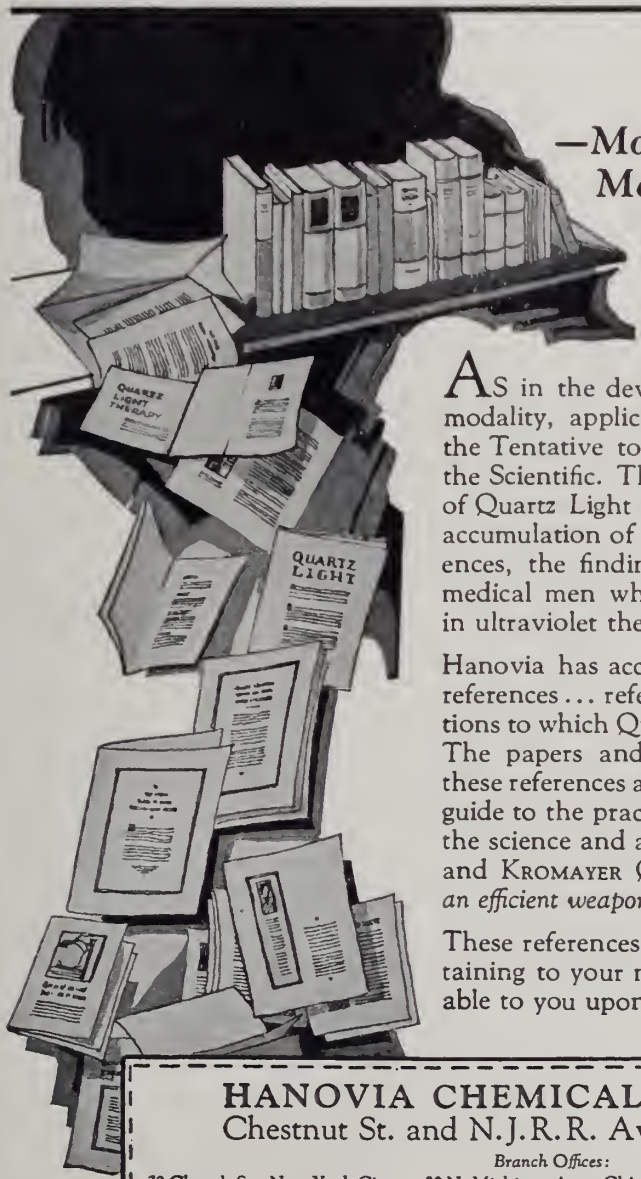

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Amiodoxyl Benzoate.—Ammonium *o*-iodoxybenzoate.—The ammonium salt of 2-iodoxybenzoic acid. The latter differs from ortho-hydroxybenzoic acid (salicylic acid) in that the hydroxy group is replaced by the iodoxyl group. It contains 42.7 per cent of iodine. For a discussion of the actions and uses, see the preceding article "Iodoxybenzoates".

Amiodoxyl Benzoate—Abbott.—A brand of amiodoxyl benzoate—N. N. R. Abbott Laboratories, North Chicago.

Capsules Ephedrine Hydrochloride—Swan-Myers, 0.05 Gm.—Each capsule contains Ephedrine Hydrochloride—Swan-Myers (Jour. A. M. A., April 16, 1927, p. 1235) 0.05 Gm. Swan-Myers Co., Indianapolis.

Ephedrine Sulphate—Abbott.—A brand of ephedrine sulphate—N. N. R. For a discussion of the actions, uses and dosage of ephedrine sulphate, see The Journal, A. M. A., March 19, 1927, p. 925. Abbott Laboratories, North Chicago. (Jour. A. M. A., September 24, 1927, p. 1061.)

PROPAGANDA FOR REFORM

Artificial Ripening of Fruits by Ethylene.—While the use of ethylene as a means of ripening fruit is of growing commercial importance, the health phases have not yet been thoroughly considered. Certain fruits and vegetables are recommended by physicians largely because of their vitamin content; whether or not this is altered by ethylene has not been determined. Possibly, also, the fruits and vegetables may be picked earlier than is the practice today, thus shortening the period of irradication by the sun. Physicians may well watch the development of this form of food enterprise; perhaps the time may come when certain everyday foodstuffs will be purchased on the basis of vitamin units. In the meanwhile, the use of vitamin-containing products in as near a "naturally ripened" condition as possible should be encouraged when used for prophylaxis against avitaminosis. (Jour. A. M. A., September 3, 1927, p. 792.)

Treatment of Pernicious Anemia.—Minot and his co-workers report good results in the treatment of pernicious anemia by means of a diet composed especially of foods rich in complete proteins and iron—particularly liver—and containing an abundance of fruits and fresh vegetables and relatively low in fat. Koessler and his associates believe that in some cases, at least, the phenomena accompanying pernicious anemia are the result of long continued deficiency in vitamin A and possibly also in vitamins B and C and propose the treatment of pernicious anemia with a high coloric diet rich in vitamins. Therefore Minot and Koessler would prescribe an adequate general diet, including a large quantity of liver and kidney. Minot and his co-workers would reduce the fats, whereas Koessler and his associates declare that butter, cream, milk and cod liver oil should be partaken of in large amounts. Macht reports that the blood serum of patients with pernicious anemia contains a toxin, and that this blood serum can be detoxified by irradiation with ultraviolet rays. Furthermore, he found that the effect of ultraviolet rays could be increased by introducing into the serum to be treated dyes which act as sensitizers. Since liver is the storehouse for blood pigments, some of these pigments may help increase the effectiveness of light and thus some of the good effects of liver diet may be connected with the liver pigments that are administered. (Jour. A. M. A., September 3, 1927, p. 793.)

Phosphobion Not Acceptable for N. N. R.—The Council on Pharmacy and Chemistry reports that Phosphobion, manufactured by Dr. Theodor Koenig, Munich, Germany (Carl F. Lauber, Philadelphia, distributor), are pills, each stated to contain zinc phosphide, 0.0025 Gm., and iron glycerophosphate, 0.03 Gm. According to the advertising, Phosphobion represents a new treatment for sleeplessness. It is claimed that sleeplessness is caused by a deficiency of phosphorus in the organism and that the phosphorus in Phosphobion has the power of supplying this deficiency. No evidence is offered in favor of the theories on which the claimed action of Phosphobion is based, nor convincing evidence in favor of its claimed action. The Council found Phosphobion unacceptable for New and Nonofficial Remedies because it is an unscientific mixture of drugs marketed under a nondescriptive name with claims that are not supported by acceptable evidence and in a way to lead to its ill advised use by the laity. (Jour. A. M. A., September 3, 1927, p. 809.)

Digitalization.—The term "digitalization" was coined to signify the full pharmacologic action of the drug to the limit of safety. Laboratorial and clinical investigations have developed the digitalization amount of digitalis to be, for a 150 pound (68 Kg.) adult weight, a minimum of 22½ grains (1.45 Gm.) and a maximum of 33 grains (2.2 Gm.). Half the minimum dose may be given at once and then 2 or 3 grains (0.13 to 0.2 Gm.) every six hours, or the other half of the minimum dose may be given on the second day. If the patient needs more digitalis for digitalization, the amount is gradually increased by 2 or 3 grains, perhaps every six hours, until symptoms of digitalization appear. Digitalization should not be attempted if the patient has previously been taking digitalis. The dosage advised must of course be greatly modified with frail, underweight persons. An overweight person, when that weight is largely due to fat, must not be given doses according to his weight. The condition of the patient must also be taken into account. Digitalization means digitalis poisoning. Such poisoning should not be inaugurated except by a careful determination of the exact condition of a patient to be treated. The general practitioner should not thoughtlessly digitalize his patient unless he has hospital or other facilities for determining the exact condition of his heart and his excretory ability. (Jour. A. M. A., September 10, 1927, p. 884.)

Gelobarin Not Acceptable for N. N. R.—The Council on Pharmacy and Chemistry reports that Gelobarin is the trademarked name under which the Powers-Weightman-Rosengarten Company markets a mixture of barium sulphate and water, containing approximately 40 per cent of barium sulphate. The preparation is proposed for use in radiologic examinations. The Council found Gelobarin unacceptable for New and Nonofficial Remedies because it is an unoriginal product that is offered under a proprietary, nondescriptive name. (Jour. A. M. A., September 17, 1927, p. 984.)

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A United Front For Child Health*

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The future of the race depends on the manner and success with which we conduct the business of living. Perhaps this particular business is the most sadly neglected of all the business enterprises in the world. It is said that from eighty-five to ninety per cent of all commercial concerns fail sooner or later. Need we express wonder then if the poorly conducted business of living is more or less of a failure and that such failure is registered in much preventable sickness, permanent impairment of health—mental or physical—or, alas, too often in premature death!

The distinguished president of the great university of Wisconsin has expressed an opinion, as to the future of the race in America, in a much more thought-provoking fashion. Glenn Frank says, "The future of America is in the hands of three men: the administrator, the investigator and the interpreter. We shall never lack for the administrator, and we have an ample supply of investigators, but there is a shortage of readable and responsible interpreters—men who can effectively play mediator between specialists and laymen." Analyzing these two thoughts, it would appear that the business of living is conducted so poorly because of the lack of interpretation of the present available medical and scientific knowledge, for progress is only made possible by the interpretation of knowledge translated into the language of the masses.

The scientist and investigator advance knowledge; the interpreter advances progress.

Modern effective and ethical advertising is based on the principle of interpretative information so displayed as to (a) arrest attention, (b) arouse an interest, and (c) create a desire. These are the three psychological phases of successful salesmanship. Every special enterprise of our modern industrial world has its staff of *interpreters,* and high salaried expert advertisers. The daily press carries millions of pages of news directed to the interpretation of our social and political life, good and bad, and the current price of all staple products; and the economic status of our great financial centers are available every morning and evening. In a word, every kind of business seems to have ample interpretation except that of the business of right living. Nevertheless an encouraging beginning in this life saving and health promotion may be noted as a summary of a few of the milestones of progress in public health, during the past twenty years, will disclose.

In 1907 there were no State Divisions of Child Hygiene. In 1927 there are 47 State Divisions of Child Hygiene; but one state as yet unorganized in this important child health work.

In 1907 there were no full time County Health Units. In 1927 there are 341 full time continuously operating County Health Units widely scattered throughout the United States.

In 1907 there were no clinics for Mental Hygiene. In 1927 there are 19 such clinics throughout the country; a recognition of a new and important phase of public health endeavor.

In 1904 there were in the United States no cities of 50,000 population or over having a chlorinated water supply which would render it safe under all conditions. In 1924, twenty years later, about 90 per cent of the cities of 50,000 population and over had their water supply efficiently protected through chlorination.

Of cities of 25,000 population in 1907 there were none which had 95 per cent of their milk supply pasteurized. In 1927, 41 such cities have 95 per cent or more of their milk supply pasteurized.

In 1906 the crude death rate per 1,000 population in the United States death registration area was 16.1; in 1926 it was 12.1.

In 1906 the infant death rate per 1,000 live births was 148; that is to say 148 babies died be-

*Presented before Joint Meeting, State Medical Society of Wisconsin and Biennial Conference of Health Officers of Wisconsin, Eau Claire, Sept. 21, 1927.

fore they were a year old out of every 1,000 born alive. In 1926, twenty years later, the rate was reduced to 75 per 1,000 live births for 28 states of the birth registration area. In the state of Wisconsin infant mortality has been reduced from 108 per 1,000 live births in 1910 to 84.5 in 1920, and to 71.5 in 1924.

In the United States in 1907 life expectancy at birth was 48 years; in 1927 it is estimated to be 58 years, a gain of 10 years during the past twenty years. Life expectancy at birth in Wisconsin, as given by the Census Bureau based on the census of 1920 is 58.81 for males and 60.75 for females, the highest in the United States with the exception of Kansas.

In 1905 the diphtheria death rate per 100,000 population was 23.8. In 1925 this rate had been reduced to 7.8 per 100,000 population.

In one exceedingly important particular, however, this remarkable progress made in the reduction of preventable deaths and in safe-guarding the health and comfort of the citizens of the United States has not been registered; namely, in maternal mortality, for we gather from the mortality rates of 1905 that the maternal mortality per 100,000 population was 14.6 and 1925 the rate had slightly increased to 14.9. In Wisconsin, figuring on a different basis, namely per 1,000 live births, the maternal mortality rate for 1919 of 4.8 had increased to 6.0 in 1924. Just why the maternal mortality continues at this high rate has not been adequately determined, but that it is matter requiring a most searching inquiry by the medical profession and the application of the best thought by those engaged in obstetrical practice there can be no doubt.

THE STARTING POINT

Perhaps the starting point for the progress noted in the cause of child health in America might be dated from 1875, for with the establishment of the Society for the Prevention of Cruelty to Children came the first organized social recognition of the problem of the child. It came about in this way. It was discovered that an adopted child was being treated with great cruelty by its foster parents. An interested social worker being unable to secure relief for the child finally called upon the Society for the Prevention of Cruelty to Animals. Upon the matter being referred to counsel it was decided that the child being an animal the society could act. The publicity given this case resulted in the formation of the Society for the Prevention of Cruelty to Children, April 27, 1875.

With attention focused upon the social welfare of the child it was logical that eventually that interest should cover its physical welfare and thus slowly the health problems of the child have challenged the interest of communities, states and nations until today they occupy the very center of the stage of activities of governmental and voluntary health organizations and the concern of the medical profession.

Dr. Philip Van Ingen in writing the history of child welfare work in the United States declares that the progress in the health of the child is a development of the twentieth century. He says, "In looking back over the past twenty years six events stand out as milestones marking incidents which in themselves may seem trivial, but which have had a tremendous influence in the course of the development of this work—(1) the publication in 1906 by the Census Bureau of the mortality statistics for the five years 1900 to 1904. Vital statistics had been published before by local communities, but it would be hard to find any report which paid much attention to child mortality. It was the aggregate and systematic statistics from the Census Bureau which first called the attention of the country at large to the appalling loss of human life during infancy and childhood—(2) the establishment in New York City Department of Health in 1908 of the Division of Child Hygiene. This was the first official admission by a great municipality that child health work was a matter worthy of and requiring special attention from a city department—(3) the Conference for Prevention of Infant Mortality called by the American Academy of Medicine in New Haven in 1909. For the first time an impressive investigation was presented to the public showing the enormous and unnecessary waste in infant life and the claim was made that it was largely preventable. As a result of this conference the American Association for the Study and Prevention of Infant Mortality was organized and the American Child Health Association, as its successor, is continuing this work of studying the problem and the best methods of meeting it. (4) The formation of the Federal Children's Bureau in 1912. That was the recognition by the Federal Government of the rights of the child and the advisability of special machinery to study and protect him. (5) The establishment of the Division of Child Hygiene in the New York

State Department of Health. This was the first State Division of Child Hygiene authorized by law and, what is more to the point, provided the necessary support to carry on an active campaign for child welfare. The following year similar divisions were created in the State Boards of Health of Kansas and Louisiana. (6) The establishment of the Birth Registration Area and the publication of birth statistics for 1915. For the first time birth statistics on which to base infant mortality rates were available for a considerable area and were compiled in a uniform manner."

To these six events should now be added four others of epoch making importance—(1) the passage by Congress of the Sheppard-Towner Act to promote infant and maternal hygiene—(2) the creation in every state in the Union but one of a Division or Bureau of Child Hygiene, brought about chiefly through the operation of the Sheppard-Towner Act—(3) the amalgamation of the national child health voluntary agencies into one organization—the American Child Health Association and (4) and much more important than all the others, the advances made in preventive and curative medicine during the past fifty years through which specific and definite knowledge as to the control of certain malignant communicable diseases has already been the means of saving many thousands of lives and will continue to save countless thousands of children's lives in the future. These mark the more important steps of progress in child health which in recent years has been memorable by an increasing and nation-wide interest in the health and welfare problems of the whole child. But despite these remarkable gains, particularly in the reduction of infant mortality, through means already mentioned, life in America's peace time cradle seems to be more hazardous than with our soldiers in combat in the world war, for of every one thousand babies born in the United States in 1924 over 70 died during the first year of their lives; more than seven times the rate per thousand of our enlisted men and officers killed or dying from wounds in combat during the world war. The Census Bureau records reveal that in 1924 there were 1,930,614 live births in the registration area of the United States and 136,730 deaths under one year of age, a mortality of 70.8 per 1,000 live births. Nor does this include the 75,817 who although born in 1924 never opened their eyes to the light of day or raised their tremulous cry in protest to an uninviting world, but simply went to swell that awful quota of stillbirths which continue to darken the pages of our statistical tables and blight the happiness and sadden the lives of thousands of American homes. Nor does this struggle for existence cease after the first year, although there is a rapidly decreasing death rate after that period of greatest hazard. In the Death Registration Area for 1924 the deaths under five years of age constitute 18.7 per cent of the total deaths from all causes, of which 5 per cent represent deaths between one and five years of age. It is in this age period that the invisible enemies of mankind, the germs of communicable diseases, exact the greatest toll in death and leave many thousands of others crippled, either physically or mentally, throughout life.

FUTURE POSSIBILITIES

This rather gloomy picture, against the background of remarkable progress in the prolongation of human life and the promotion of health, is painted for the purpose of emphasizing anew the fact that much yet remains to be done to further reduce the human life waste, a great deal of which is preventable, and to promote those conditions and assemble those resources that may be brought to bear upon communities and states to grapple with their child health problems in a united front.

While there is much yet to be learned in respect to the causes of early infant deaths, yet there is enough known in relation to prenatal care of the expectant mother which, if it were made widely available in the language of the masses, would undoubtedly operate to the saving of many infant and many maternal lives. Herein is the field for the interpreter, the one who can bridge the gulf between knowledge and practice, who can banish ignorance and who, like the salesman, can arrest attention, promote an interest and create a desire for sound and scientific information clothed in language that can be understood by a person of average mentality and which carries over into positive and intelligent action.

A careful study of infant and child mortality will disclose the type of medical service required to meet the child health needs. Of the tremendous loss of life under one year of age in 1924 we find over one half (54.5 per cent) of these deaths occurring during the first month and the majority during the first seven days. To those dying so early must be added those born dead. The enormous stillbirth rate and early infancy mortality

point to causes operating before birth, which in a majority of cases can be reached only through special care of the expectant mother. Therefore, the first community concern in providing effective health service for children and mothers is to supply simple and yet practical means by which every expectant mother can secure such medical advice and care as will minimize the hazard of childbearing to mothers and insure vigorous and well-nourished children at birth. It is admitted that an effective and practical set-up for prenatal service in small towns and rural communities is not an easy task, but that prenatal care results in the saving of human life, and thereby lessens human anguish and life waste, the following experimental evidence will prove.

PRENATAL CARE

In Boston, among 4,353 cases given prenatal care by the Maternity Service of the Instructive District Nursing Association (1), there was a maternal mortality *of 2 per 1,000 cases, in 1920.* For the city of Boston at large there was a maternal mortality of *7 per 1,000 births.* This saving was effected in spite of the fact that only one fourth of the cases were reported to the Instructive District Nursing Association before the fifth month of pregnancy. The effect of this prenatal care on the stillbirth rate was not marked; the rate for cases receiving prenatal care being 35 per 1,000 births, that for cases having postnatal, but no prenatal care, being 39 per 1,000 births.

The mortality (under two weeks) of infants born to mothers having prenatal care was 13 per 1,000 live births; the rate for infants having postnatal, but no prenatal care, was 21, and for the city of Boston, the rate (under two weeks) was 37.

The Brooklyn Visiting Nurse Association (2) gave prenatal care to 1,000 women, 44 per cent of whom had supervision for two months or more. This series of cases had little medical care in the prenatal period. The results of this series are compared with those among 1,000 of their cases receiving no prenatal care. Maternal mortality in both groups was the same, three deaths per 1,000 cases. The stillbirths of the group receiving prenatal care were ten less than among those not receiving prenatal care (25 stillbirths among the former; 35 among the latter). Neonatal mortality was also more favorable among the infants of women having prenatal care. The neonatal mortality in this group was 22, while the neonatal mortality of the group having no prenatal care was 41.

Among 1,000 consecutive deliveries given prenatal medical and nursing care under Beck (3) at the Long Island College Hospital up to 1921, there were four maternal deaths. No report is made of the maternal mortality for a control group. A valuable control for the stillbirth and neonatal mortality rates is afforded by two series of cases of the Visiting Nurses Association, the first of which had nursing care in the prenatal period for one to seven months, but no "systematic medical supervision;" the second, cases having no prenatal care.

The stillbirth rate for Beck's cases was 19 per 1,000; among Visiting Nurses Association cases having prenatal nursing, but no medical, supervision there were 25 stillbirths, and among the cases having no prenatal supervision the stillbirth rate was 35 per 1,000. There were six deaths of infants under 14 days among Beck's cases; among the Visiting Nurses Association cases, having prenatal nursing care only, there were 22 deaths of infants of this age period, and among the Visiting Nurses Association cases having no prenatal care 41 deaths.

In the Columbus Hill District of New York City, among 656 pregnancies of colored women having prenatal supervision for three months or more by the nurses of the New York Association for Improving the Condition of the Poor (4) the maternal mortality was 4.6 per 1,000 deliveries, in the period 1917-1923. Among 568 colored women receiving prenatal care from the New York Association for Improving the Condition of the Poor for less than three months, the maternal mortality was 10.6 per 1,000 deliveries. The maternal mortality for the Borough of Manhattan, 1916-1920, was 9.1 per 1,000 deliveries; that for Harlem (a more comparable district because of its large colored population) 10.5 per 1,000 deliveries. Stillbirths constituted 4 per cent of the total births to those mothers having three months or more of prenatal care, 6.6 per cent of the total births to mothers having less than three months of prenatal care. Neonatal mortality was 21 per 1,000 live births for New York Association for Improving the Condition of the Poor cases having three months or more of prenatal care, 50 for their cases having less than three months' prenatal care. A greater contrast is offered by the neonatal mortality rate for Harlem (having a large colored population with little prenatal supervision) which was 68, *over three times as large* as the rate for New York Association for Improving the Condition of the Poor cases having prenatal care.

In Minneapolis, in a series of 2,000 cases given prenatal care by Adair and Maland (5), including "a somewhat higher percentage of abnormal cases than the common run of obstetric practice," the maternal mortality was 3.3 per 1,000 live births (period ending May 1, 1923). The maternal mortality among the cases at the Swedish Hospital—cases having less prenatal care than the Adair and Maland series, was 6.5 per 1,000 live births in 1923. At the Minneapolis General Hospital, cases also having less prenatal care than the Adair and Maland cases, the maternal mortality was 7.5 per 1,000 live births in 1921, 2.0 per 1,000 live births in 1922. Stillbirths constitute 3.7 per cent to the number of live births of this series, while in the Swedish and Minneapolis General Hospital the stillbirth ratios were 4.7 and 4.4. The Adair and Maland series showed also a more favorable neonatal mortality—a rate of 23, compared with rates of 30 and 56 for the Swedish and Minneapolis General Hospital, patients of which received less prenatal care.

In Detroit (6), among patients of prenatal clinics constituting one-sixth of all pregnant women of the city, the maternal mortality was 3.5 per 1,000 confinements, in the period 1922-1924. For the city of Detroit, as a whole,

the maternal mortality in the same period was 6.75 per 1,000 confinements. Puerperal septicemia, the mortality from which was 3.24 per 1,000 confinements for the entire city of Detroit, caused a mortality of but 0.79 per 1,000 confinements among women attending the prenatal clinics, in the same period. The same marked difference in favor of the women having prenatal care is shown by the stillbirth rates. There were 36 stillbirths per 1,000 live births among women attending the largest prenatal clinics, 52 stillbirths per 1,000 live births for the city of Detroit. The difference between the stillbirth rates for white and colored is brought out by further data. The stillbirth rate for white mothers attending the largest prenatal clinic was 26 per 1,000 live births, while for white mothers in the city of Detroit the rate was 48. The stillbirth rate for colored mothers attending this prenatal clinic was 44 per 1,000 live births, while for colored mothers in the city at large, having little prenatal care, there were 112 stillbirths per 1,000 live births.

Neonatal mortality among the infants of mothers attending the prenatal clinics was 26 per 1,000 live births, while the rate for the city at large was 44.

Detroit's 1925 experience (7) shows further results proving the value of prenatal care. The maternal mortality among 463 mothers reporting to the city's prenatal clinics within 16 weeks from the onset of pregnancy was 2.1 per 1,000 births; for 825 mothers reporting between 16 and 28 weeks after the onset of pregnancy the maternal mortality was 2.4 per 1,000 births; while 710 mothers reporting 28 weeks or more after the onset of pregnancy the maternal mortality was 5.6 per 1,000 births. Comparative data on stillbirths are not reported.

Detroit's 1926 maternal mortality rates amply confirm the conclusion to which these figures point. The prenatal clinic cases have a maternal mortality rate of 3.3, while the rate for the city at large was 7.2 puerperal deaths per 1,000 live births. It is of interest that maternal mortality among childbearing women in the city at large increased slightly between the period 1922-1924, and 1926, while that among the prenatal cases seen at the city clinics showed a slight decrease.

Infant mortality among the infants of mothers having prenatal care in 1925 was 70 while that among infants of mothers in the city at large was 80. The infant mortality rates vary according to the length of prenatal care, infants of mothers having five months or more of prenatal care having an infant mortality rate of 65, those having two months or less of prenatal care, an infant mortality rate of 85. These data are not yet available for 1926.

An interesting demonstration of prenatal care in a rural area was carried on in Tioga County, New York, by the New York State Department of Health and the Maternity Center Association of New York in 1925 and 1926. Dr. Lobenstein opens his report of the work with a statement recognizing "the problem of providing expectant mothers in small towns and in rural communities with reasonable safeguards during pregnancy and labor," which is "one that is surrounded, on the whole, with more difficulties than are met with in the average urban community." In spite of this fact, 50 per cent of the 253 new patients seen in the second year of the Tioga County demonstration sought prenatal care voluntarily.

The number of cases cared for is comparatively small and the results are therefore not presented as rates. There were no maternal deaths in either 1925 or 1926. In 1925 there were 145 live births and four stillbirths. Seven infants died under six weeks of age.

In 1926 there were 225 live births, five stillbirths, and four deaths of infants in the neonatal period (under six weeks of age).

WORK IN WISCONSIN

Your State Board of Health and several of the City Boards of Health have made a most commendable beginning in their efforts to foster prenatal work, which should receive the sympathetic support of the medical profession if further progress is to be registered in Wisconsin.

A united front in a practical and comprehensive plan, state-wide in its scope, for prenatal care and instruction to expectant mothers would give greater dividends in health unimpaired and lives saved, than by any other conceivable measure of which we now have knowledge. It is worthy of your thoughtful consideration. May I invite your attention to the work of the Maternal Welfare Joint Committee of which Dr. Fred L. Adair of Minneapolis is chairman. This committee has prepared and published in the American Journal of Obstetrics and Gynecology, "Standards of Prenatal Care," an outline for the use of physicians. I am sure a copy will be promptly sent to any physician upon request to Dr. Adair.

We shall find too in a further study of the causes of infant mortality that large numbers still die from "diarrhoea and enteritis" a disease much more common among bottle fed than breast fed babies and due in a majority of cases probably to unwholesome milk. This fact points to another way in which a community may safeguard the lives of babies as well as children and adults: by providing a clean and safe milk supply. The production and distribution of safe milk is so easy to accomplish that it is entirely fair to state that the community which fails or neglects to provide a safe milk supply for its people is guilty of a grave offense against society and must be morally responsible for the results of such neglect. The fact that deaths from diarrhoea and enteritis during infancy are approximately four times greater among bottle fed babies than among those that are breast fed emphasizes the importance of every mother breast

feeding her baby if it is physically possible. The responsibility resting with mothers in this regard is a responsibility that is reflected in the greatly increased hazard of life to bottle fed babies.

Parent education in this field of health endeavor is imperative. Here we find a service of the greatest usefulness, for the wisely trained visiting or public health nurse, and the volunteer health and social agencies, to bridge the gap between the uninformed parent and the ethical physician. For it must be remembered that the final answer to these problems rests in the hands of the medical profession.

Referring again to the causes of mortality in the one to five year age group we find the chief causes of sickness and death are the communicable diseases of childhood, particularly those of the respiratory tract, which suggests at once that our children must be guarded against needless exposure from those suffering from or exposed to any of the communicable infections, and, what is of more importance, should be immunized against those diseases which science and experience have shown afford protection. The time is not many years hence when death from diphtheria will be the subject of a coroner jury to fix criminal responsibility for life needlessly sacrificed. It is at this point that the usefulness of the interpreter is so obvious. If parents generally understood the ease and certainty with which their children may be protected from such diseases as diphtheria, smallpox and typhoid fever and at so little expenditure of time and money there is little question but that the great majority of susceptible people would be speedily rendered immune. I believe it would not be out of place to inquire if the medical profession in this state have assumed their whole responsibility in this vital and important matter. Here again is the opportunity for the authorized interpreter for the medical profession. What parent would longer withhold the protection for his child, that comes through modern accepted methods of artificial immunization, if the scientific knowledge now in the custody of the medical profession was made available to every parent in language or form so simple and convincing as to break down the barriers of ignorance and the taboos of superstition?

I plead for more interpreters. A united front, through a working committee representing the State Medical Society, the State Board of Health and the United Press, might serve a most useful purpose in giving the people authoritative information in matters of scientific medicine and public health in the language of the press, which is the vocabulary of the man on the street.

I conclude with the words of Mr. Herbert Hoover, President of the American Child Health Association, who in a recent address said: "Our work is racial defense. If we want this civilization to march forward toward higher economic standards, to moral and spiritual ideals, it will march only on the feet of healthy children." I would add, it is the task of preventive medicine and public health to chart the course to a physically and mentally normal people. This can best be accomplished by all agencies, medical, official and voluntary agencies, closing up the ranks and presenting a united front for child health. Competition, if such is possible in the field of public health, must give way to cooperation, emulation and team-play, with the medical profession assuming the leadership. Will the Wisconsin State Medical Society accept the challenge!

For discussion see page 613.

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The Health Officer, Medical Profession And The Laity*

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It is with some degree of misgiving that I have chosen for this paper the title designated on the program because I am conscious that much consideration has been given to this question during recent years. It was thought, however, that this subject would be particularly fitting in view of the fiftieth anniversary of the State Board of Health and the first meeting of public health officials jointly with the State Medical Society. I trust, therefore, that my effort will not be in vain in trying to emphasize the importance of securing and maintaining a closer inter-relation between the health officer, organized medical profession and the laity for mutual benefit.

The medical profession has consistently manifested an altruistic spirit concerning the public. With the remarkable advancements in medical science, the opportunities of the profession in the prevention and treatment of disease have been proportionately increased. In turn, the public is becoming more enlightened with reference to the possibilities of preventive and curative medicine, and as a consequence is exacting of the physician a larger and more efficient service. Organized medicine has always occupied a position of leadership not only in the advancement of medical science, but also in the prevention of disease and promotion of the public health. The public is, therefore, expecting of the profession continued interest and constructive leadership in the solution of problems that confront us in the control of disease, the alleviation and relief of human suffering, and in the social betterment of community life.

In order to have a clearer perspective and broader vision, it may be well to recount briefly some of the outstanding needs of the public based on careful studies during recent years. Let us begin with maternal and infant hygiene. Available data indicates that on an average about twenty-five per cent of the births of this country are unattended by physicians. This means that a total of approximately 700,000 births in the United States are improperly cared for or are attended by poorly informed and in the main ignorant midwives. One of the most serious public health questions with which we are confronted is also the inadequate medical and nursing supervision afforded to mothers and infants during a period when such aid would be invaluable. Wisconsin is perhaps more fortunate than many other states in having a relatively small percentage of midwives attending cases of confinement. However, in one state with which I happen to be familiar, reliable statistics show that out of 45,050 total births during 1922 there were 22,741 who were attended by physicians; and there were 21,703 who were attended by midwives. Ninety-eight per cent of these midwives could neither read nor write. This means that approximately fifty per cent of the births of that state were not attended by physicians, but on the contrary the mother was administered to during the most trying ordeal of her life by the flickering light of ignorance and superstition.

It seems clear that there is no problem today which merits the consideration of the medical profession more than giving adequate protection to the health of mothers and infants and the reduction of infant mortality. When it is realized that the number of deaths of women from all puerperal causes in the registration area of the United States during 1925 was 15,315, and that approximately 161,961 die annually before reaching the age of one year, the problem of maternal and infant hygiene becomes one of the first magnitude. Moreover, the records of the Bureau of Census show that 108,478 infants or about sixty-seven per cent die prior to three months of age. It is also significant that there has been no material reduction in the maternal death rate in the registration area during the last two decades. It is probable that not less than seventy-five per cent of this mortality is preventable. These conditions are a reflection not only upon the laity but a challenge to the organized profession for intelligent and constructive service to motherhood.

HEALTH OF CHILDREN

During recent years, nation-wide interest has been stimulated in child health and as a result surveys have been made which reveal that there is an appalling need for improvement in the health of children of the preschool and school ages. There are approximately five million children in

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the United States under two years of age and of this number a conservative estimate indicates that 1,500,00 suffered from diarrhoea and enteritis during 1925. Added to this, there were 36,300 deaths reported as attributable to these infections. There are also approximately 30,000,000 children in the States of school age and of this number careful estimates show that more than 1,000,000 suffer annually from four of the so-called children's diseases, namely, measles, whooping cough, scarlet fever and diphtheria with the attendant sequelae. Moreover, many of these cases receive no medical attention or the medical service is delayed or inadequate. The gravity of this situation becomes more serious when it is known that much misinformation is conveyed to parents concerning the danger of these diseases even by members of our own profession. It is, therefore, not unnatural for carelessness to prevail among the laity concerning the so-called diseases of childhood. Then too, there are at least fifteen per cent of school children who suffer from eye defects which means a total of about 4,500,000 with defective vision. Because inadequate medical service has been provided for thousands upon thousands of these children, scores are not only injured permanently in health, but become "repeaters" in school and cause an unnecessary economic waste to the nation. There are also more than 3,000,000 children of school age being retarded in growth and development, and who are also handicapped in school because of diseased tonsils and adenoids. In turn, there are as many as 15,000,000 children who show defects in mouth hygiene and thousands are suffering from physical inefficiency, and as a consequence, they are being retarded in school, resulting in a large financial loss in the use of funds for public education. Then, there should be mentioned the large army of undernourished and underweight children which varies from twenty to thirty per cent. This means not less than 6,000,000 children are undernourished and who may be classed, potentially, as cases of tuberculosis. Much of the malnutrition among children is due indirectly to physical defects, infections, parasitic infestations and bad environment. These facts show that there is a great physical drain upon the vitality of the child life of the nation for which improper provision has been made in medical supervision and which offers an opportunity for increased medical service.

Then comes the period of adolescence, the age of sex impulse—the age during which occurs the largest percentage of venereal infections. Careful estimates indicate that about one-tenth of all deaths are caused by luetic infections and at least twenty per cent of the inmates of our institutions for the insane are there because of the ravages of syphilis. This, therefore, presents a problem of grave import not only from the viewpoint of conserving public health, broadly speaking, but also from a purely economic standpoint. When it is further realized that these diseases are the principal causes of sterility and serve as the chief source of supply of patients in gynecological wards of our hospitals, this offers a serious problem in the perpetuation of a vigorous civilization.

Statistics show that the venereal diseases took more men out of the line of battle during the recent war than shot, shell and gas. This shows in an unmistakable way the inroads that are made by these infections which are broadcast among the civil population. They not only produce sterility but physical inefficiency and enormous waste in productive capacity. Our experience and observation in practical public health point to the fact that about twenty per cent of all cases of venereal disease are receiving no medical attention. Moreover, a considerable percentage of such cases become indifferent to scientific treatment and follow the advice of friends or come under the influence of quacks or are allured by patent medicine advertisements into taking proprietary remedies. Obviously, the incidence of venereal disease presents a medical and public health problem of tremendous importance and scope, and one which will require the most constructive, educative and scientific leadership in its solution.

PRESENT NEED OF LAITY

The enumeration of these outstanding problems not only serve to emphasize and convince us concerning some of the needs for an increased medical service; but I think an analysis of this data also leads one to conclude that the greatest medical need of the laity at the present time is a better appreciation of the possibilities and benefits to be derived from scientific medicine. It is probable that not more than sixty per cent of the people have proper appreciation of the value of medical science. Because of the ignorance of the public and, as a logical sequence, the indifferent attitude of the laity, is there any wonder that cults, pathies, isms, and charlatans of every kind

gain headway in offering their wares to the people? This condition of society can be changed only by a persistent, systematic, and intelligent attitude on the part of the organized profession in the education of the people relative to personal and community hygiene, the principles involved in the treatment of disease, the benefits derived from medical discovery and the intrinsic value of scientific medicine. It is, therefore, evident that the profession and the public have a large mutual interest which unites them in a common task, namely, to supply the increased demand for a larger medical service, and also one that affords a closer correlation between medical practice and community public health activities.

Having presented the above facts, the question may be asked, can a more definite contribution be made by the organized medical profession of a state not only in the enlightenment of the public but in the supply of the larger medical service needed and required to adequately conserve the public health? In directing an answer to this question, it may be well to recall that there are at present fifty-one component county and district medical societies in Wisconsin. Many of these societies have regular meetings for maintaining high scientific standards in the practice of medicine and some of them doubtless make generous contributions for the improvement of the public health. During recent years, a number of the county societies have very properly merged into district organizations and there is perhaps a tendency on the part of the physicians in each county to lose their individuality as a group with reference to the problems of the county in which they practice. The greatest strength of the medical profession does not consist in the individual but in the organized effort of its membership. It is, therefore, extremely important that the county and district medical societies of a state determine ways and means that will enable the physicians of the constituent counties to advocate and carry out a more definite policy relative to (1) the education of the people in preventive medicine, (2) periodic medical examination for those who are apparently healthy and (3) formulatng a plan which will enable the physicians of a county to assume definite responsibility for any corrective work that may be necessary among children, and which may be done in accord with the ethics of the medical profession. Otherwise, in time, this need will be supplied.

EDUCATION OF THE PEOPLE

The question may be asked, is it possible for the physicians to formulate a plan in the respective counties in the state that may be used in a systematic way in the enlightenment of the public concerning the prevention of disease and the benefits derived from scientific medicine? It would seem to me that there should be arranged by the physicians of the county at least two or more public health meetings, in different communities, during consecutive years, for the purpose of discussing local health problems. This would afford opportunity for assuming a more definite attitude to the laity in the solution of health problems. However, such a plan should only be carried out in cooperation with the state and local health authorities. This would serve to establish between the profession and the collective minds of the public a more sympathetic relation. It would also be a means of causing the medical profession to assume its rightful place in directing public opinion not only in the physical salvation of the people, but also in increasing and maintaining that influence and prestige which is fundamental in the accomplishment of any great service.

On March 24, 1927, a conference on public health was called by the Secretary of the American Medical Association with the approval of the Board of Trustees for the purpose of discussing subjects pertaining to the relation of the physician to public health. I am of the opinion that this meeting marked the beginning of a new era in the mobilization of practitioners of medicine for a larger professonal and public health service. A number of excellent papers were presented with a view of determining more clearly the present status of medical practice relative to activities of official and non-official health agencies; and the part which the organized profession should play in the modern scheme of public health.

I think it is generally agreed among health officers that it is desirable for the medical profession to participate more actively in this undertaking and manifest at all times intelligent leadership in public health movements. In an interesting and constructive paper by Dr. Arthur Holbrook of Milwaukee before the conference above referred to, the same viewpoint is stressed in the following statement: "In my opinion the medical profession leaves the work of the allied organizations too much in the hands of the laity." Some one has said that "medicine has a poor vision when

it comes to seeing socially," and the indictment is more or less true. There would be far less criticism to offer these organizations if physcians were a bit more far-seeing, if they sought membership and activity in these agencies, gave freely of expert medical advice, interpreted and explained technical aspects to lay members, gave talks before clubs and other groups to help educate the public in the objects and activities of antituberculosis, Red Cross, family and infant welfare and like activities. On their side these organizations should realize that their greatest usefulness is attained when they supplement the work of the public health authorities and work in close cooperation with them. Kipling's oft-quoted lines might well be made familiar to their membership: "It ain't the individual nor the army as a whole, but the everlasting teamwork of every bloomin' soul."

PERIODIC EXAMINATIONS

Making of periodic medical examinations of apparently healthy people.—It may be well to introduce one or two witnesses in order to emphasize the need for the consideration of this question. In 1925 and 1926, the Life Extension Institute of New York examined 169,236 people, males and females, including all races representing various industries and living in different parts of the country. It was found that eighty-five per cent of them were in need of medical attention. This includes those needing corrections of visual defects and possible surgical attention as well as medical supervision and treatment. Only twelve per cent were under the doctor's care at the time of the examination, but probably not all of the defects found by the medical examiner of the Life Extension Institute were under treatment. This Institute has examined to date more than 500,000 people, showing that at least sixty per cent of those examined were in need of medical treatment and only about twenty per cent of those needing treatment were receiving it. Again during the period of recruiting soldiers for the world war, examiners frequently found that young men apparently in the very vigor of manhood showed physical defects which were making inroads on their health and of which they were wholly unconscious. Moreover, a large percentage of them would have developed chronic conditions had not advice been given and opportunity offered for medical attention. Then, there is the difficult problem of reducing the incidence of the so-called degenerative diseases, which are showing a marked increase in death rate in this and other countries. In Wisconsin, since 1908, the death rate from nephritis has increased twelve per cent, heart disease forty-nine per cent, and cancer forty-two per cent. The early recognition of these maladies is the only means in the light of present knowledge for preventing and retarding their progress. No measurable results are being secured at this time in dealing with the diseases or disabilities of advancing age.

These conditions show the fundamental need of periodic physical examinations, especially, after passing the age of forty. This should be done not only by physicians in their practice but also through effective organization of the medical profession. Would it not be possible for the county and district medical society to formulate a plan for making periodic health examinations as an educative demonstration so as to impress the public with the necessity and value of life extension work? Of course, these examinations are designed to detect early evidence of functional disturbances before there is discomfort, inconvenience, interference with work, or anxiety has led the person to seek medical advice for the treatment of an established disease. The methods employed should be those used in the diagnosis of disease. However, such an examnation should be made with discriminating care and accuracy if the public is to be impressed and the desired results obtained. Frequently hygienic measures must be advised rather than curative agents. Moreover, the attainment of results will largely depend on a "follow-up" procedure by the physician. This is indispensable.

We realize that when a person comes to a physician it is usually because the individual feels the need of medical attention or he is of the opinion that disease has developed, although he may not be suffering materially from any particular disability. It is, however, gratifying that in recent years there has been an increased interest on the part of the thoughtful laity in having physical examinations made in order to obtain a correct estimate of their physical condition—a health audit—to determine the state of health and to seek advice and guidance in improving the physical standard, and also to obtain suggestions for avoiding the disabilities of advancing years.

To facilitate this movement, it would seem possible for the physicians in a county to organize in cooperation with the state and local health agencies

so that opportunity may be afforded for the examination of apparently healthy people as a demonstration clinic, educative in purpose, and charging a nominal fee for making the examination. I do not believe that very successful results will be obtained in the promotion of this movement without a more definite cooperation between the health official and the practitioner of medicine. The two should be mutually interested in developing a plan which will serve to impress upon the laity the worthwhileness of a periodic examination. Doubtless the usual educational methods will cause a limited number of the more intelligent people to seek such advice, but the great mass of citizens, who are most in need, will be slow in responding except through demonstration methods. This group of citizens has certainly not yet been reached.

CORRECTIVE WORK

Formulating a plan by the physicians in a county for corrective work among children.—We know that a large percentage of children are in need of medical attention and, what is even worse, their parents are in many instances uninformed and indifferent concerning their physical welfare. Would it not be practicable for the county or district medical society to develop a plan of work in cooperation with the state and local health departments which would enable it to function not only for the purpose of enlightening the people relative to the possibilities of scientific medicine, but also to demonstrate in a practical way the advantages accruing from the correction of physical defects which are a menace to child health and cause inefficiency among scores of children? As a profession, we have advocated for many years the importance of the examination of school children. We have stood in season and out of season for this phase of public health work, realizing that the child is the most potential unit of society. It is, however, the concensus of opinion that when such examinations are made and the parent merely notified of the defect, without providing ways and means for corrective work, that not more than ten per cent, and usually a smaller percentage of children, have the defects corrected. When a considerable expenditure is incurred in order to make an examination of the children of a county or district, such a result could not be regarded as an economic procedure in public health practice.

It is, therefore, imperative that some plan be agreed upon by the profession which will cause a larger percentage of children who show defects to have them corrected. The great need in this practically unsupplied field of medicine should certainly enlist the interest and cooperation of the medical profession in rendering a larger service for the conservation of child health, and which will also serve as no other phase of public health to blend the interests of the public and the profession for mutual benefit. The profession will experience increased opportunity for service and financial gain—the medical attention given will result in the development of a more vigorous citizenship which is so essential for the solution of the economic problems in the commercial progress of the state and nation.

In reviewing the literature and records of your State Health Department, I have been much impressed with the constructive program and results obtained under the efficient direction of your State Health Officer. I find that Wisconsin had the lowest death rate from typhoid fever for 1925 in the United States, with the exception of Massachusetts and Minnesota, that is, 2 per 100,000 population. This is a reduction of ninety-five per cent in typhoid since 1908. Likewise, the mortality rate of tuberculosis shows a decline of forty-two per cent, that of diphtheria fifty-eight per cent, and infant mortality has been decreased forty-five per cent during the last two decades. These outstanding achievements have contributed largely to adding an average of eight years to the span of human life in this state since 1908. A large measure of the success attained in securing these gratifying results should be attributed to the efficiency of your state health organization. There will be no difficulty ahead in establishing the proper reciprocal relation between health departments and the medical profession in upbuilding the health of the citizens in a community or state provided we have at the head of such a service a trained man, and one who is imbued with the ideals and purposes of the profession. We need men in these positions who are not influenced by partisan politics, but who endeavor to consider each problem from a scientific viewpoint.

The health officer should be in sympathy with medical practice and acquainted with the problems and difficulties with which the practitioner is confronted. He should insist on the rights of physicians in the dispensaries and clinics, and secure the cooperation of the public by referring cases for treatment to the family physician. Personally,

I have never been associated professionally with a health officer who has not honestly endeavored to carry out this objective. The other kind doubtless is found. However, any health officer or health department that advocates a policy which is disregardful of the rights of the practicing physician is doomed to failure regardless of the degree of efficiency attained and the worthiness of the cause presented.

Unfortunately, there are members of our profession who are not informed relative to the development of the modern health program and who assume a critical attitude to health activities that are perfectly legitimate and based upon sound scientific and educational procedure. These, however, are in a minority. The large majority of physicians of this country are cordial toward and are heartily in favor of public health activities. I understand that in your own state there has been a wholesome cooperation in the main between the profession and the state and local health authorities. This should be so when it is the policy of your State Health Department to consider with equity the welfare of the medical profession and the laity, and with due regard for the traditions and ethical principles underlying the practice of medicine. This should be done by every official and voluntary health agency. If we can utilize the 90,000 members of the American Medical Association in the practice of preventive as well as curative medicine, a great forward step will be taken in the physical betterment of mankind.

STATE MEDICINE

However, in our effort to establish a more wholesome relation between the health officer, medical profession and the laity for mutual benefit, much confusion has developed during recent years because of a misconception pertaining to so-called "state medicine"—the modern bugaboo of the profession. We seem at times to have organized our fears into an illusion and are erecting a specter. In reality, there is no accepted definition of "state medicine." It may mean anything that the commonwealth desires to do for the physical welfare of its citizenship and from this point of view, the insane hospitals, deaf and dumb institutions, charity hospitals and so forth could be so regarded. But of late there has been a tendency to refer to the State Department of Health by many well-meaning physicians as developing a program which may lead to the adoption of such a scheme as a part of our body politic. This position cannot be sustained. In reality, state medicine is subsidizing the medical profession on the basis of a panel system such as the health insurance act created in Germany by Bismarck in 1883 and later adopted in modified form in England. "State medicine," therefore, is subsidizing the medical profession by the government primarily for treatment and cure, and has a different objective from that of the prevention of disease through public health agencies.

While there may be activities of the state health organization which are looked upon as somewhat undesirable by members of the profession and that may require adjustment, it does not seem to me wise to consider these activities as in any sense state medicine, or as having any tendency toward its development. On the contrary, in my judgment, if the time should ever come when it would be necessary for the medical profession to stand as a unit for justice and witness strongly for the truth, the best argument which can be presented to defeat "state medicine" will be the fact that our profession has liberally and consistently stood for and promoted public health activities in the prevention and control of disease, and only on this ground can such legislation be defeated.

We are facing a day of specialists, group medicine, preventive medicine, institutional service, conservation of child health, the control of infectious disease through governmental agencies; and whether we want to or not, as a profession we must look the fact squarely in the face and realize that with the dawn of a new era in the physical reconstruction of civilization there will be new adjustments between the established health agencies, the medical profession and society. This is inevitable. It is already upon us. The wise physician will face the fact without fear, and with altruism, realizing that the medical profession has won a permanent place in society based upon service and that it is only by keeping the true ideal of service that this position can be maintained. As Doctor Haven Emerson has so well stated in a recent address, "Let us share the courage of the poet and welcome changes based on truth."

> "New times demand new measures and new men;
> The world advances and in time outgrows
> The laws that in our fathers' day were best;
> And, doubtless, after us some purer scheme
> Will be shaped out by wiser men than we—
> Made wiser by the steady growth of truth.
> The time is ripe, and rotten ripe, for change;
> Then let it come; I have no dread of what

Is called for by the instinct of mankind.
Nor think I that God's world would fall apart
Because we tear a parchment more or less.
Truth is eternal, but her effluence,
With endless change, is fitted to the hour;
Her mirror is turned forward, to reflect
The promise of the future, not the past."

DISCUSSION

DR. W. D. STOVALL (Madison, Wis.): I have enjoyed these papers very much, and I don't know that I can say very much about any of the papers, except that of Dr. Leathers'. Dr. Leathers gave me such a stimulation and so delighted me that I feel I cannot let it go by without recommending it to your serious consideration. As you know, for a number of years here in the state I have been interested in trying to interest the physicians or give them more personal interest in the public health work which goes on in the state. And I have felt so keenly that the whole success of a public health program depends upon the cooperation of the physician that this paper comes in and seems to me to say exactly the things that should be said now.

There are two or three reasons why the physician is so important to the public health work in the state. Of course, he is important in every locality, but in large communities like the large cities where they have a perfect or as nearly perfect as possible public health organization, they can carry on a great deal of this work by physicians which they can hire in the department. The pressing need for the cooperation of physicians is particularly critical in the rural districts. In these districts it is not possible to hire full time health officers or trained health officers, and the community medical problems must be solved by somebody. It is, therefore, up to the local physicians to help solve these problems or to solve them in their community.

You will remember at the last meeting of our Society, the State Medical Society, there was a proposition made in the report of the Committee on Health and Public Instruction suggesting a means by which the physicians of the state could cooperate in opening child welfare clinics, pre-school clinics in the various communities. That program has never gotten very far, but I think it demands your consideration. I hope, after Dr. Leathers' paper, you will think this matter over and decide that after all it is possible for the physician to contribute greatly to the organization of these clinics and not only to the interest of his community in solving the community medical problems, but to his own interests personally and financially. (Applause.)

DR. V. A. CHAPMAN (Milwaukee): Possibly some of the health officers will wonder what right an ear, nose and throat doctor has in breaking into this program. The fact that Dr. Leathers mentioned the great number of school children of the early school age suffering from diseased tonsils and adenoids gave me the opportunity that I have looked for for a couple of years to say something about that from the standpoint of prophylaxis.

I don't know that we hear anything said about the cause of adenoids, and when the child gets into school and needs the attention of the surgeon for the removal of adenoids, which he does need very often, it is too late to think of the prophylactic part of it. I believe that a lot of these adenoids can be prevented and it is within the province of the pediatrician and those who have to do with infant feeding and welfare to prevent them.

I believe that the cause of adenoids is largely a matter of infant feeding. I believe that the lack of certain vitamin elements which should be in the food is the cause of adenoids. That is one of the causes of adenoids. The other cause is the lack of proper air for a child to breathe, both causes acting in the same way. The upper respiratory tract, in my opinion, has a lot to do with the oxygenation of the blood. I believe that nature makes an effort to increase the mucous membrane surface of the upper respiratory tract in order to increase the oxygenating power of that membrane, and here is a place where nature does as she often does in an effort to correct something. She overdoes it and eventually defeats her own purpose.

In order to provide more mucous membrane surface in the upper respiratory tract there is an increase in the adenoid tissue in the nasal pharynx, with consequent obstructed breathing, and the purpose is defeated. I believe that the lack of proper vitamin has the same effect as the lack of oxygen in this condition, and if somebody would pay more attention to the proper nourishment of the children or work out the problem of what deficiency in vitamin causes this I believe that we would get a lot further with this adenoid and tonsil proposition. It is a question of prophylaxis and until some way is developed to prevent them we will simply just have to keep on removing diseased or obstructive tonsils and adenoids until the end of all time. The tonsil tissue does partake to some extent in these excess developments, but the condition which necessitates removal of the tonsils is usually secondary to the adenoid. The obstruction to the nasal breathing causes tonsil trouble which necessitates their removal.

Another thing is this: It is not just adenoid tissue which grows in excess and blocks nasal breathing. The mucous membrane of the turbinals, even in the younger children, becomes very much overdeveloped, especially at the posterior end of the lower turbinal, the place where the nose opens into the nasal pharynx, and therein is one of the reasons why so often the failure to correct the child's mouth breathing results, when tonsils and adenoids have been removed. I have seen case after case where tonsils and adenoids have been removed, and properly removed, too, and still the child cannot breathe through the nose. By examining the posterior choanae (and that can only be properly done by the nasaopharyngeal periscope passed through the nose) we find a great mass of soft tissue blocking the posterior nares. In all cases where the necessity is found for the removal of adenoids for relief of obstruction to nasal breathing, the posterior end of the nasal turbinal should be carefully examined beforehand, and that soft mass taken off at the same time. Otherwise the results you want will not be procured. (Applause.)

DR. EDWARD EVANS (La Crosse): Before clos-

ing the discussion, I would like to ask one question. The men doing obstetrics and now engaged in general surgery see a great deal of poor obstetretics. I would like to ask Dr. Crumbine, in relation to the statistics he quoted, if there are any statistics relating to morbidity.

DR. S. J. CRUMBINE (New York City): Answering the question concerning morbidity, I know of no information on that. I don't think it is available. (Applause.)

Rectal Examinations; Helpful Points*

By W. A. FANSLER, M. D.
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It is the purpose of this paper to call to your attention some of the factors in proctology which are met with in every day practice. In the past, instruction in rectal diseases as given in our medical colleges has been woefully inadequate. I feel reasonably certain in assuming that the proctologic knowledge of most of the men present is the result of their own personal observations and text book descriptions. It may be this lack of instruction in student days which cause many physicians to so diligently avoid rectal examinations. As far as unpleasantness is concerned rectal examinations are no more disagreeable than vaginal and but little more difficult, nor is the equipment necessary more complicated or expensive. A bivalve speculum such as Pratt's, an anoscope with a slot as an Ives or Hirschman, a Kelly open air proctoscope, a few probes and a head light suffice in most cases.

In order that a patient may be examined in a minimum amount of time and a maximum amount of knowledge gained from the observations made, a certain definite routine is necessary. In my own practice the procedure is about as follows: The patient is placed on the left side in the Sim's position with the parts exposed to a good light, either natural or artificial. The buttocks are retracted and the external parts inspected. By this we may see the bluish enlargement of external hemorrhoids, skin tags and excoriations, the lower margin of an anal fissure or the opening of a fistulous tract. Occasionally an extruded polyp or a prolapsed internal hemorrhoid may be seen externally. More rarely lesions due to tuberculosis, syphilis or some unusual pathological condition is noted. The next step is a digital examination. The finger, protected by a finger cot or a rubber glove and well lubricated is carefully inserted into the anal canal. If pain is produced the finger is withdrawn and the anal canal is anesthetized by the local application of ten percent cocain solution or if necessary by the injection of one percent procain solution. One reason for a digital examination preceding any instrumentation is that the finger tip is sensitive and we may learn without causing the patient undue pain whether anesthesia is necessary and whether or not instrumental examination may be safely done. By digital examination we discover spasm of the sphincters, indurated areas, anal narrowing, hypertrophied papillae, polypi and the majority of rectal cancers. One other maneuver of value is the palpation of the peri rectal tissues between the index finger and thumb. This bifinger examination reveals any masses in the ischio rectal fossae or elsewhere adjacent to the lower rectum and anus. By this method tumor masses, blind internal fistulas or small abscesses, which are not apparent either externally or proctoscopically are discovered. The next step is the examination of the anal canal and lower inch of the rectum. For this purpose a slotted speculum is used. This examination is quite important as crypts of Morgagni, the anal papillae and the entire hemorrhoidal area is situated in this terminal portion. The speculum is inserted and the obturator withdrawn. Any hypertrophied papillae, internal hemorrhoids or low lying polypi immediately fall into the slot. Fissures, ulcerated areas and other abnormalities may be clearly seen. The speculum is rotated until the entire circumference is inspected. The crypts of Morgagni should be carefully examined. This can be done through the anoscope but more adequate examination is possible if a bivalve speculum can be inserted and spread. This spreads the crypts open so that their bases can be readily inspected and any changes from normal noted. With a hooked probe the pouch like endings of the crypts are explored for sinuses. This is important for it is from inflammation in these blind pockets that the majority of fistulas and fissures develop. This examination having been satisfactorily completed the remainder of the rectum is now examined. The simplest method of doing this is to have the patient assume a knee chest position with all tight clothing removed. In this position the abdominal contents fall downwards against the diaphragm thus creating a negative pressure in the lower abdominal and pelvic cavi-

*Presented before the B-P-W-S-B County Medical Society, Frederic, Wis., Sept. 7, 1927.

ties. When the proctoscope is inserted air rushes in balooning out the rectum so that the rectal valves and wells of the bowel are plainly visible. Unless the bowel is unusually angulated or spasm or contracture is present the proctoscope may easily be passed from twenty to twenty-five centimeters which is the length of the average scope. This is done with the obturator withdrawn and the bowel walls observed as the tip of the instrument is advanced. This method precludes the possibility of rupturing or injuring the bowel wall. This is a real danger if the gut be inflamed and friable and undue force is used. Manipulation of the instrument is quite safe but if it cannot be inserted without undue force it is best to abandon the attempt and resort to other methods of examination.

It is, of course, impossible in this short paper to cover more than a small portion of rectal symtomatology. For this reason I will only mention a few points which are more or less fundamental and will open avenues for further thought. One of the most frequent symptoms of which patients complain is bleeding. If the blood occurs only with defecation, is bright red in color and not accompanied by pain, the chances are that it is from the internal hemorrhoidal area. If associated with pain the blood is most likely from some lesion in or about the anus. Dark or coffee ground blood is usually supposed to come from some point higher up in the gastro intestinal tract. This is often the case but not infrequently an internal hemorrhoid may bleed between bowel movements and the blood will collect in the rectum and colon and become dark and discolored. If mucus or pus is mixed with the blood an inflammatory condition of some kind is present. This may be a proctitis, colitis, ulceration, abscess or malignancy. The majority of carcinomas after they become well developed ulcerate and discharge mucus or pus. Abnormal discharge should always be viewed with suspicion.

PAIN A FACTOR

Pain is also a factor in rectal diseases. In fact it is the symptom which most always impels the patient to seek medical advice. He may have severe bleeding or other marked symptoms and still delay examination, but with the advent of pain he quickly seeks his medical adviser. In considering rectal pain there are certain points of interest. Its character, whether or not it is continuous, whether it precedes, occurs with or follows bowel movements, must be borne in mind. Most rectal pains are increased by bowel movement so this fact must not be allowed to over shadow other characteristics of the pain. A continuous pain is almost always due to some acute condition as an abscess, proctitis, a thrombotic hemorrhoid, an acutely inflammed fissure or an ulcer involving the anus. Pain preceding bowel movement means pathology in the lower most part of the rectum, usually involving the anorectal junction. Pain during defecation indicates trouble in the anal canal, usually an ulcer or fissure. This pain may cease with bowel movement or may last several hours. It is well to keep in mind that hemorrhoids are seldom painful unless strangulated or thrombosed. Pain occurring in a case of apparently simple hemorrhoids is usually due to some complicating condition.

Protrusion is the third of the triad of common rectal symptoms. This is usually due to one of the three things, hemorrhoids, prolapsus or a pedunculated rectal tumor. Prolapsus is differentiated from hemorrhoids by the fact that the protrusion is the pinkish rectal mucosa and not the reddish or bluish plexus of hemorrhoidal vessels. The pedunculated tumor can be differentiated by the isolation of the pedicle which may be either string or strap like.

I realize that this is only a brief sketch of a few high lights of proctology but time does not suffice to do more. I do however want to call your attention to a few salient points concerning the most serious rectal affection—that of rectal carcinoma. In the first place there is a general impression among the laity that rectal carcinoma is painful. In ninety-five percent of cases this is not true until late in the disease. In fact when the patient begins to notice pain the disease has frequently developed so far that radical removal is impossible. The only carcinomas which are painful in the early stages are those occurring in the anal canal and are squamous cell in character or those of the adenomatous type developing just at the ano rectal juncture. These comprise only five percent of cancers occuring in the rectum and anus. Another point of interest is that at least eighty percent of carcinomas of the rectum can be felt on digital examination. Any non-pedunculated rectal mass having a hard nodular feeling is most likely malignant, at least it should be considered malignant until proven other wise. Also contrary to general belief, rectal cancers, except those occurring about the anal canal, usually metastasize late. If seen in a reasonably early

stage they offer a good chance of permanent cure. The reason so few rectal cancers are operated successfully is because the patients present themselves to the surgeon in an advanced stage of the disease. If the growths are discovered and operated in the earlier stages there should be at least fifty percent permanent cures and an operative mortality of less than ten percent. Seen in the late stages there is but little hope of permanent cure. Colostomy is the only surgery advisable. If radical operation seems to be indicated, the only type of operation which should be done is one which involves a permanent colostomy and the posterior removal of the entire rectum well above the growth. Our only hope for reducing the mortality of rectal carcinoma lies in making an early diagnosis. This can only be done by making adequate rectal examination on every patient presenting rectal symptoms. No patient who complains of rectal disturbance should, without examination, be dismissed with an ointment or a suppository and told to come back if he was not relieved. Not only this but patients should be educated to the fact that rectal bleeding or discharge may mean some serious disturbance. Just because they passed a little blood or mucus five or ten years ago and nothing developed does not mean that their symptoms today may not be due to an early rectal carcinoma. Let us educate the public to these facts and then do our part by making adequate examinations. If this be done the hopeless attitude of the public toward rectal cancer will be dispelled and the mortality should be cut in half.

Pernicious Anemia

By CHARLES E. CONSTANTINE, M. D.
Racine

Pernicious anemia, for many years a baffling and practically hopeless disease, is now nearing solution. The work of the last three years by Minot and others is the most encouraging piece of work done so far. The causative agent of pernicious anemia, however, is still in the realm of the unknown. The prevailing opinion among medical men for a good many years has been that pernicious anemia was caused by the presence in the blood stream of an unknown hemolytic agent. Many other hypotheses have been advanced, but none could be definitely confirmed either by clinical findings or experimental tests. It is the purpose of the writer here to present a new theory which is not based on any personal work, but only on already known facts, and which theory, to the writer's knowledge, has not been advanced heretofore. The theory, in brief, is to the effect that pernicious anemia is caused not by the *presence* in the blood stream of a harmful agent which hemolyzes the erythrocytes, but, to the contrary, by the *absence* of a certain agent from the blood stream, without which the life of the red cells is greatly shortened; and that this missing agent is normally produced by the liver. The liver has several functions, some of which are still unknown. It is the writer's opinion that one of the liver functions is the production of a substance which acts in the capacity of a protector to the red cells, preventing their premature destruction. That such an anti-hemolytic agent is actually secreted by the liver is confirmed by the long known fact that the erythrocytes of a patient who is jaundiced are abnormally resistant to the hemolysis of hypotonic salt solution. This would indicate two things, (1) that in the blood of a jaundiced person there is present an anti-hemolytic substance, and (2) that this substance, most logically, entered the blood with the bile from the liver.

If the assertions made above are true, then it may be said that the diminution or absence of the normally present anti-hemolysin in the human blood (this deficiency being caused by an impairment of one of the liver function) produces a symptom complex hitherto known as pernicious anemia. The marked improvement noted in these cases by Minot and others when liver, or fractions of same, were administered can then be readily explained by the assumption that the lacking anti-hemolysin, so called, is replenished by the liver when it is taken internally, just as the lacking thyroid hormone in cases of myxoedema is made available when animal thyroid gland is given orally.

By way of digression the writer desires to touch upon the much disputed subject of hematagenous jaundice, for it seems to have a definite relation to the matter at hand. Is it not possible that this form of jaundice is a response of a normal liver to the stimulus of increased hemolysis, in order that more of the anti-hemolytic substance be poured into the blood stream, that the process of hemolysis might be quickly arrested?

THE JOURNAL CLINIC

Diagnostic Problems

By L. M. WARFIELD, M. D.
Milwaukee

In the last Journal we had a case of a man of 57 years with an enlarged spleen who was seen in 1919 and came to the hospital in August, 1927, much emaciated. He had slight leukocytosis, a few myelocytes in his blood and had slight fever while in hospital and died shortly following a hemorrhage from the stomach.

DISCUSSION

This case proved to be more complicated than it appeared to be. When he was seen by me in 1919 a diagnosis of chronic leukemic myelosis was made which was based upon the history, physical findings and blood examination. I then lost track of him for nine years when he came to the county hospital apparently with the same disease. However, with the enlarged liver and the enlarged spleen and without a very high leukocyte count it was thought by some that he might have Banti's disease. However, Banti's disease is not universally recognized as a specific, definite disease. It is looked upon, in many places, as only a series of symptoms which might result from several diverse causes. Cases have been reported of typical, clinical Banti's disease, in which the chief pathological lesion found was chronic thrombophlebitis of the splenic vein. Furthermore, in order that one should diagnose Banti's disease, if he accepts such a disease, one must adhere strictly to Banti's criteria, the chief of which is leukopenia, and the second is an anemia of the chlorotic type. Neither of these two signs were present in this man, and moreover his spleen was entirely too large to diagnose Banti's disease.

As far as we know the myeloid form of leukemia is the only disease which gives such huge spleens, such as this man had. When a case of Banti's disease arrives at the stage of cirrhosis of the liver and is near the end, ascites always takes place. So one might say that there was no question of Banti's disease in this man. Hemorrhage from the stomach, however, is one of the very common symptoms of Banti's disease, and when this man had a hemorrhage from the stomach it seemed to add an important symptom for this diagnosis.

The x-ray showed spotting in the lungs which suggested to the radiographer disseminated tuberculosis, and he so suggested in his report. Clinically, however, there was no evidence of tuberculosis. The irregular fever which the man had could readily be accounted for by leukemia or by Banti's disease in the last stages. The hemorrhage from the stomach was not explained during life.

Autopsy cleared up some of these obscure points. In the first place the hemorrhage undoubtedly came from the duodenal ulcer which was found. Had he lived long enough there might have been blood in the stools. Although macroscopically no tubercles were seen, on microscopic examination the lungs contained miliary tubercles. The spleen was filled with caseating masses and scattered giant cells, besides the complete destruction of the architecture of the spleen by the leukemic cells. Malpighian bodies were for the most part destroyed and the pulp was filled with blood and new cells. The trabeculae were much thickened. The whitish areas seen on gross specimen were areas of caseation. The liver showed no leukemic nodules but there were many miliary tubercles. No tubercles were seen in the section of kidney which were examined. The kidneys showed the typical lesions of arteriosclerosis.

The full diagnosis therefore was chronic leukemic myelosis, miliary tuberculosis, duodenal ulcer and arteriosclerosis.

It is interesting that this man had leukemia for many years and quite probably his death was caused by the tuberculosis rather than by the leukemia.

A NEW PROBLEM

A man of our own profession, 57 years old, asked me to see him one day in September, 1927. I found him sitting in a chair in the sun parlor of his home looking rather ill but complaining only of weakness and some loss of weight. He had been to his office four days before this and had

seen patients. However, he said that for at least two months he had not been feeling quite himself. There was no pain anywhere, no fever so far as he was aware, no cough, no sweating. Mostly loss of "pep". His food did not taste as good as usual. He had had some painful defecation and some blood in the stool at times. He had had no difficulty with his urine. There was nothing of importance in his family history. His past history also revealed no serious illnesses. As he did not seem in need of immediate attention it was two days later when he was seen again and examined. This time he was in bed and looked really ill. His voice was weak. He seemed utterly exhausted. On examination the head revealed no lesions. The pupils were normal. The thyroid was not enlarged and no glands were palpable anywhere. The tongue was coated and moist. The lungs and heart showed no abnormal changes except that the pulse was 100. The abdomen was flat, the spleen was felt as a firm round edged mass at the costal border. There was no tenderness. The liver was of normal size. It could not be felt. No rose spots were visible. The reflexes were normal. Rectal examination revealed a fairly large, somewhat boggy but smooth prostate gland. There was a small mucous polyp just inside the sphincter. His temperature was 101.5 and for the past two days (the only time it had been taken) it ranged between that and 99.4 I could make no diagnosis, suspected typhoid fever and put him in hospital for closer observation. The first blood count was Hb 75 per cent, red cells 4,190,000, white cells 294,000, of which many were myeloblasts and myelocytes.

He rapidly grew worse, seemed too weak to talk, and began to dribble urine. His condition suggested a surgical kidney and a blood urea nitrogen showed 194 mg. per 100 c.c. Another blood count in three days showed 386,000 white cells. He was taken home, became comatose with rapid pulse and died eight days after he was first seen.

A partial autopsy showed a smooth peritoneal cavity. Both kidneys were large, the left especially. The capsules stripped readily, leaving a smooth mottled reddish and yellowish-white surface. The upper pole of the left kidney was of a uniform yellowish-white color. Both ureters were dilated at their lower ends, the left being larger and about the size of a lead pencil. The bladder was contracted, thick walled. On opening it there was about 50 c.c. of cloudy ammoniacal urine. The whole mucosa was filled with punctate hemorrhages with a hemorrhagic trigonitis. The median lobe of the prostate projected into the bladder for 2 cm., forming a valve resembling the epiglottis. The pelves were not dilated. Cut sections of the kidneys showed cloudy swelling with whitish streaks in the cortex. There was no pyonephrosis or pyelitis. He did not die of acute myelogenous leukemia, although he certainly had the disease.

Primary Malarial Infection; Report of a Case

By A. G. SCHUTTE, Interne, and B. HALLMAN, Bacteriologist,
Mt. Sinai Hospital, Milwaukee

A Milwaukee boy, age 14, spending his summer vacation at a cottage on Lake Kegonsa, near Stoughton, Wisconsin, became ill on July 31st with headache and general malaise. After spending a week in bed at the cottage the patient was taken to Mount Sinai Hospital, Milwaukee.

He was admitted at noon August 7th, with a temperature of 104.8 degrees, pulse rate of 96, and respiratory rate of 32. He gave a history of having afternoon headaches and chills. There was no respiratory, cardiac or urinary distress. There were no gastro-intestinal symptoms except for lack of appetite and constipation. He slept well at night and was refreshed in the morning. The past history was negative.

The patient was well developed, appeared very tired, his eyes were congested and his cheeks slightly sunken. His tongue had a moderately heavy yellowish-white coating, but was moist. His ears, nose and throat were normal. The lungs were clear and the heart tones of good quality. There was no tenderness, rigidity or distention of the abdomen. The spleen appeared enlarged on percussion but was not palpable. The superficial lymph glands were not palpable. The skin was clear, but very warm. There were no areas of tenderness over the long bones. The reflexes were normal and Kernig's and Brudzinski's signs were negative. A tentative diagnosis of typhoid fever was made.

Stool, urine, and blood cultures were negative for bacillus typhosus. The urinalysis was negative except for a trace of albumin. The white blood count was 5,500. The Widal test was negative. The patient was very comfortable in the morning with a temperature of 99 degrees to 100

degrees; pulse rate of 70-80 degrees, and respiration rate of 20. A chill occurred daily between 1:30 and 3:00 P. M., the duration of which varied from 20 to 45 minutes. The chill was followed by a feeling of extreme warmth which ended toward evening in a profuse sweat. The temperature range during the daily paroxysm was 104.5 to 106 degrees, but slowly fell to 99 to 100 by the following morning.

The observation of the daily paroxysm of chill, hot stage, and profuse sweat led one to think of the probability of a malarial infection. The blood smears examined on the third day after admission contained organisms having the morphology of the malaria parasite. The cells containing the parasites were slightly decolorized. In the non-infected cells there was an occurrence of microcytes, macracytes, polychromatophils and poikilocytes. No nucleated red cells occurred but numerous red cells showed basophilic granulation.

From the clinical and laboratory findings, the case was diagnosed as double benign tertian malaria. Although the chills occurred daily, there was a difference between the paroxysms of alternate days—a difference consisting of time of onset, severity, and relative length of stages. The reasons for calling the parasite Plasmodium vivax were: the organisms were actively amoeboid, the infected red cells were larger than normal, the presence of Schüffner's dots, and the circular shape of the schizont. The blood findings at this time were indicative of secondary anemia, there being 3,070,000 red cells, 57% hemoglobin, 46% neutrophils, 3% lymphocytes and 5% mononuclears.

On the first day, August 12th, following specific treatment the paroxysms ceased and on the following day the patient was taken home. On August 25th the patient was feeling well. The blood smears showed no parasites present but numerous cells with basophilic granulation were noted. On September 24th the patient was in excellent health and the blood samples showed 4,560,000 red cells, 86% hemoglobin, 12,500 white cells, 57% neutrophils, 3% eosinophils, 1% basophils, 33% lymphocytes, 3% transitionals and 3% mononuclears.

So far as could be determined the incidence of primary malarial infection have been extremely rare in this vicinity in recent years. For this reason it was thought that this case should be of sufficient interest to warrant its report.

ORTHOPEDIC NURSING SERVICE

This Special Nursing Service is given by the Visiting Nurse Association under the supervision of Florence Phenix, a registered nurse, who has had a special course in Physiotherapy at Harvard Medical and three years of experience with the Chicago Visiting Nurse Association. The service in muscle re-education is available to any person living in the County of Milwaukee. For further information call Visiting Nurse Association, Broadway 41.

DR. CAHANA APPOINTED

Dr. Stephen Cahana, 928 Hackett Avenue, Milwaukee, was appointed during October a member of the State Board of Health for the seven-year term expiring in 1934. Dr. Cahana succeeds Dr. Otho Fiedler of Sheboygan.

Dr. Cahana is a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin and the American Medical Association and has been practicing in Milwaukee for many years. He is assistant professor of clinical medicine at Marquette University.

INCREASING MORTALITY FROM HEART DISEASE

Four reasons are suggested by Henry Albert, Des Moines, Iowa (Journal A. M. A., Oct. 15, 1927), as accounting at least in part for the increase in the number of deaths from heart disease noted during the last thirty years. 1. The increase in the number of persons who live long enough to attain the "heart disease" age. More persons than ever before are now attaining the age of 45 years and over. Mortality in heart disease occurs chiefly after that age. 2. Decrease in the number of deaths from infectious diseases, especially tuberculosis. Every person succumbs to some disease, accident or old age. If, during the course of years, the death rate per given age group from certain diseases is reduced, persons attaining that age group are more likely to die in increasing numbers from some other disease. With advancing years, many of the cases of the "some other" disease are likely to be heart disease. 3. Old age, which may account for a slightly increasing number of cases that may properly be regarded as resulting from a normal senescent process. 4. Increase in the proportion of the population "maimed" by certain infectious diseases. Heart disease is in large part the result of injury to that organ by an infection which occured some or, indeed, many years previously. Whereas the morbidity rate for scarlet fever and probably also acute rheumatic fever is practically the same today as it was twenty or more years ago, there has been a decided reduction in the mortality rate. Many of those who survive an attack of scarlet fever or acute rheumatic fever are more or less maimed by it. On that assumption, there is now and has been for some years past an increase in the proportion of the population which has been "maimed" by conditions like to lead to heart disease.

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SERVICE AVAILABLE

In this space each month will be set forth the essential details of each of the fields of service to the members developed by the State Medical Society. It is the hope that these short articles will prove of value to the reader.

MALPRACTICE AND MEDICAL DEFENSE

"The malpractice suit generally comes out of a clear sky, it comes to the greatest as well as to those less widely known; and like lightning, it has been known to hit the same place more than once." Editorial, Wis. M. J., Dec 1926.

"Malpractice cases are on an increase in Wisconsin." Statement of legal authorities.

* * * *

The State Medical Society of Wisconsin for many years has offered a type of defense restricted to members, which has repeatedly proved its worth. For a fee of $2.00, payable with the annual dues for 1928, the Society offers to the member the advice and services of its legal counsel from the time the civil action is threatened to the time it is settled,—through an appeal to the State Supreme Court, if that be deemed necessary. The records show that the Society has lost but 8 of 193 cases it has defended in the past nineteen years.

No revenue accrues to the Society from this service. Indeed, it has been a source of loss in some years. The great advantage of the service is not alone a moral one but the services of one firm of counsel who have handled malpractice cases in Wisconsin totaling nearly nine hundred. It is obvious that such firm, by reason of practice, is well acquainted with the special and technical field of malpractice suits and with the important decisions made within that field. In addition, monies derived from this service are used in the field of preventive effort.

"I never dreamed I would be sued for malpractice" is the opening statement of every report of a case of threatened case. The Society has expended several hundreds of dollars in the defense of a single important case. This service is available to you for two dollars a year.

* * * *

Many malpractice suits would never arise if physicians would observe the following suggestions:

Do not sue for your statements until the two-year period has elapsed. A threatened malpractice suit has often been used to counterclaim the bill by the unscrupulous.

Be careful what you say about the "other" doctor's treatment. Do not say that which you are not willing to say on the witness stand under oath. Every suit started is the focus of a circle of suits.

Be chary of giving "offhand" opinions to attorneys. Secure all the facts and history first.

The honest man deserves your aid but not the dishonest or deluded.

EDITORIALS

THERE IS WORK AHEAD

IN THE gradual conquest of diphtheria and other maladies of the communicable type, the medical and lay public have a convincing demonstration of the efficiency of medical measures. It is encouraging to note, for example, that in Wisconsin we already have a number of communities where nearly 100 per cent of the school children have been protected against diphtheria. Auburn, New York, is an outstanding example of toxin-antitoxin's value in the fight against that disease. Not a death from diphtheria has occurred there in more than five years.

Since 1920, to cite another example, all children at Mooseheart, Illinois, have been immunized with toxin-antitoxin, with the result that not a single case has since occurred, despite numerous exposures. The previous record was from 16 to 20 cases yearly in that large colony of young people.

We think this evidence completely refutes the argument that biologics are not efficient in preventing certain types of communicable diseases. But our plea at this time is along other lines; it is for a more popular recognition that, by the control of certain communicable diseases, we are able to point the way to the control of those ailments of adult ages that are increasing rather than decreasing in extent. These are the so-called constitutional diseases that are yearly piling up greater losses in human life.

Physicians and health administrators alike have for years emphasized that to curb these diseases effectively, men and women must undergo medical examinations regularly and act upon the advice given. The public has responded, as indicated, with growing fervor to the pleas for preventive measures for children's diseases, and the emphasis is now being directed to the education of adults in the necessity for preventive measures for themselves, and much money and effort have been given to this movement. Yet the surface has only been scratched. We are witnessing the familiar fact that the public is hard to convince that they need a physical examination when they feel well. How to overcome this erroneous impression, to rout the common apathy and instill in men a saner view of their duty to themselves in this important matter of their physical assets and liabilities, is a phase of the battle yet to be waged.

C. A. H.

ACUTE APPENDICITIS; ITS MORTALITY

At intervals one meets in the current literature, articles dealing with the subject of acute appendicitis in which attention is called to an increasing death rate. For example:

A. M. Willis in an article entitled, "The Mortality in Important Surgical Diseases, Especially Appendicitis" (S. G. & O. March 1926, p. 318) feels that the mortality rate in surgical conditions is not declining with increase in diagnostic and technical skill.

Sivertsen and Dahlstrom (Minnesota Medical J., Aug. 1927) discuss "Acute Suppurative Appendicitis, Factors in Mortality" and find that the mortality has increased during the last fifteen years.

Carr and Deacon (J. Mich. St. Med. Soc., Sept. 1927, Vol. XXVI, p. 358) under the title "Appendicitis, A Study of Michigan Statistics", find an increased mortality after the thirtieth year of age.

Bauer and Clark (J. A. M. A., Sept. 1927, Vol. 89, No. 11, p. 844) very recently discuss the subject under the title, "Controllable Factors Affecting the Mortality of Acute Appendicitis, Some Fallacies of Present Day Teaching," in which they state that statistics show an increase in the mortality of acute appendicitis during the past ten years, and attribute this unfortunate condition to two factors: 1, delay in operation, and 2, administration of laxatives. Neither of these are conconsidered to be the fault of the surgeon, who must bear the responsibility of the operation and its result.

Consideration of this subject of delay in operation will show that it may be divided into two divisions; viz.,

(a) Delay in giving advice, a professional fault, and

(b) Delay in accepting advice, a layman's failing.

(a) Delay in giving advice to operate early in

acute appendicitis is due either to a diagnostic error, or to an undeveloped pathological sense on the part of the physician, and must be corrected by proper education of the medical man.

(b) Delay in *accepting* advice (if thoroughly well given) is solely a layman's right and responsibility; such delay may be due, of course, to many factors, but there is one that seems to have been comparatively unrecognized and insufficiently emphasized, that is, unsatisfactory results.

The decision of the patient to accept the advice to submit to operation (a procedure not without danger, and costly as to time and money) calls for *confidence* in the advisor which is founded upon a familiarity with similar cases that have terminated satisfactorily after operation; these are consciously, or subconsciously, contrasted with others in which operation was not performed and terminated unsatisfactorily or disastrously, in consequence acceptance of the doctor's advice is usual.

Factors tending to prevent the acceptance of such advice will include a knowledge of cases in which the diagnosis of acute appendicitis is made, operation advised or urged, is rejected and the result is a satisfactory recovery; but a more important and unrecognized cause is the acquaintance of cases of appendicitis in which operation has been followed by a recurrence of symptoms, an unsatisfactory result.

These cases are rarely the same but, of course, the layman is unable to differentiate between an acute appendicitis and a so-called chronic appendicitis; an appendix operation is, to him, an appendix operation, and the patient is better or not better following such procedure.

By some strange psychology many favorable results are more than counter-balanced by one unsatisfactory outcome, a fatality may often be satisfactorily explained, but a return of symptoms is usually inexcusable.

The large percent of unsatisfactory results, i. e., return of symptoms following operation for so-called "chronic appendicitis" is undoubtedly often responsible for a sense of hesitancy or reluctance to accept the advice that calls for prompt operation, for relief of symptoms which may have subsided without incident a number of times before, and acts as an indirect cause of the increasing mortality rate in acute appendicitis.

All of which emphasizes the necessity of correct diagnosis before advising or performing operations for any condition, even for supposedly as simple a matter as chronic appendicitis, as poor "results" following such operation may be an important factor in failure to secure proper treatment in serious acute cases with a resultant increase in mortality rate. F. G. C.

THE PHYSICIAN'S CAPITAL

ONE does not need to be a socialist, or even to be socialistically inclined, to subscribe to the proposition that a very considerable distinction should be made in taxes paid on *earned income* and that from *invested capital.* The earnings of a physician, for example, are far more ephemeral than the salary of a bank president or head of any other business corporation. Capital stock holdings of the latter may insure continuance of a salary through many months of total or partial incapacity. This in addition to the dividends on capital owned.

Not so with the doctor. Like those of any casual day laborer, his earnings stop when he stops. Furthermore, his income like that of a mine, a tract of timber, or any other *vanishing property* is very definitely exhausted as time goes on. Well invested capital, on the other hand, increases with time and thus becomes increasingly profitable.

H. E. D.

SUDDEN DEATH

Every issue of our Journal carries paragraphs such as the following:

"Dr. —— died suddenly at his home on ——. Age 53."

"Dr. —— died on June 30th while at work. Age 53."

"Dr. —— died suddenly on ——. Age 42."

"Dr. —— died suddenly on Sept. 10th at the home of a patient. Age 50."

"Dr. ——died on Nov. 11th while on his way to the home of a patient. Age 51."

At the end of the obituary notice will be found the usual statement, "Surviving him are his wife and children."

Physicians owe no less to their wives and children than men in other walks of life. At a time when the State Medical Society weekly is advising hundreds of thousands of laymen to have a periodic health examination, it is indeed the lax physician who does not follow his own prescription.

Are we scolding? We wonder if it isn't needed.

THE PRESIDENT'S PAGE

Arthur W. Rogers

ADJUSTMENT

NOT so long ago a gentleman was telling of the fortune he was building up by the manufacture of suspenders. Then came the belt. The suspender passed and likewise the business. This is an example of a man so devoid of vision and the physical, mental and moral equipment to enable him to adjust himself to new conditions that he registered a failure. Again, how often we find men in the fifth and sixth decades of life breaking because they fail to adjust themselves and their activities to the requirements of increasing years. In short our happiness and success in life depends at all times, for the most part, upon proper adjustment.

What can be said of the individual in this matter applies equally to groups and organizations.

In the busy rush of life the years pile up so rapidly that too often we fail to sense the changing conditions about us and we suddenly discover ourselves on "Main Street." Times and conditions are changing, and changing rapidly. We witness this in religious, social and economic activities as well as in professional lines. No individual or group of individuals would attempt to do business today as it was done twenty years ago. Big business grows bigger and more influencial by forming combinations. Our country has become so prosperous and populous that the voice of the few and weak can no longer be heard. Success grows more and more dependent upon numbers and reserve,—reserve of men and dollars.

Our state society is progressing favorably in numbers, but how about the dollars? Here I take pleasure in quoting from a letter from Dr. Olin West appearing in our November State Journal:

"In these unsettled times no organization can go very far wrong in providing for emergencies of any kind. We seem to be passing through a period of reaction and readjustment, and it is difficult to make wise decision with respect to permanent policies, or to foresee what even the near future may have in store. The wise thing, it seems to me, is to make provision for whatever may come by setting aside funds which may be used on the reasonable demands of any new situation that may develop."

My final appearance on this page is an appeal to the medical profession of the state for its moral and financial support toward the establishment of a "foundation" for our State Society which will enable us to make adjustments to those problems and emergencies which surely await us.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

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TERM EXPIRES 1929
7th Dist., Edward Evans.....La Crosse
8th Dist., T. J. Redelings.....Marinette

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Crawford	J. J. Kane, Prairie du Chien	C. A. Armstrong, Prairie du Chien.
Dane	W. D. Stovall, Madison	Hans H. Reese, Madison.
Dodge	L. M. Bachhuber, Mayville	A. A. Hoyer, Beaver Dam.
Door	John Hirschhoeck, Forestville	T. C. Proctor, Sturgeon Bay.
Douglas	P. G. McGill, Superior	J. W. McGill, Superior.
Eau Claire and Associated Counties	G. W. Beehe, Eau Claire	H. M. Stang, Eau Claire.
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Green	Edward Blumer, Monticello	J. F. Mauermann, Monroe.
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Iowa	A. D. Brown, Mineral Point	M. W. Trentzsch, Highland.
Jefferson	W. C. Becker, Watertown	A. C. Nickels, Watertown.
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Lincoln	E. K. Morris, Merrill	W. H. Bayer, Merrill.
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Marathon	W. E. Zilisch, Wausau	Verne E. Eastman, Wausau.
Marinette-Florence	T. J. Redelings, Marinette	M. D. Bird, Marinette.
Milwaukee	C. H. Stoddard, Milwaukee	E. L. Tharinger, Milwaukee.
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Wood	J. C. Hayward, Marshfield	V. A. Mason, Marshfield.

SOCIETY PROCEEDINGS

BROWN-KEWAUNEE

Dr. R. C. Hamill, professor of nervous diseases at the Rush Medical College, Chicago, addressed the members of the Brown-Kewaunee County Medical Society at Hotel Northland on October 20th. His subject, "Diseases of the Spinal Cord," was illustrated by lantern slides and was preceded by a clinic held from 5:30 to 6:30 in the lecture room at the hotel. Dinner was served at 6:30, with music by the reformatory orchestra. This meeting, the first on the winter program of the society, was well attended. *M. H. F.*

CHIPPEWA

On Monday, October 31st, the Chippewa County Medical Society was host to the Eau Claire and Associated Counties Medical Society. A seven o'clock dinner was served at the Hotel Northern, Chippewa Falls, after which two very interesting addresses and a lively discussion followed. Dr. Elmer Sevringhaus, Madison, spoke on "Diabetes and the Use of Insulin" and Dr. Wm. S. Middleton, also from the University, presented a paper on "Treatment of Pneumonia."

The society met again on November 14th, when the following officers were elected for the ensuing year: Dr. C. B. Hatleberg, Chippewa Falls, president; Dr. Wm. C. Henske, Chippewa Falls, secretary; Dr. A. J. Somers, Chippewa Falls, delegate to the state convention.

Dr. H. W. Meyerding of the Mayo Clinic talked on "Fractures" and Dr. W. H. Goeckerman, also of the Mayo Clinic, discussed "Itching Skin in Diagnosis." Both addresses were accompanied by lantern slides. *W. C. H.*

COLUMBIA

The members of the Columbia County Medical Society met at Hotel Emder at Portage on Wednesday, October 26th. Following dinner at the hotel Dr. Robert Burns, Wisconsin General Hospital, read a paper on "Osteomyelitis" and Dr. Philip Green, also from the hospital, spoke on "The Relation of Iodine to Thyroid." Dr. R. C. Buerki, superintendent of the Wisconsin General Hospital, spoke briefly on "The Progress and Value of the University Medical School at Madison." *H. E. G.*

CRAWFORD

The Crawford County Medical Society met at Prairie du Chien on October 27th, when the following officers were elected for the year 1928: President, Dr. T. E. Farrell, Seneca; Vice President, Dr. I. E. Clark, Wauzeka; Secretary-Treasurer, Dr. C. A. Armstrong, Prairie du Chien; Delegate to state meeting, Dr. A. J. McDowell, Soldiers Grove, and Alternate, Dr. O. E. Satter, Prairie du Chien. *C. A. A.*

GRANT

The twenty-fifth annual meeting of the Grant County Medical Society was held in the Grantland Club rooms, Lancaster, Monday, October 24th, Dr. E. S. Hayman, president, presiding.

The following interesting program was given: Dr. Wm. J. Mayo, Rochester, appeared first on the program, with an address on "The Relation of Pure Science to Medicine." In order that all who wished might hear his address, an open meeting was held and the doctor spoke from the stage in the Grantland Theater. All who had the privilege of listening to this address understood and enjoyed it, laymen as well as members of the medical profession.

The society then adjourned to the Grantland Club rooms and the program continued. Dr. Harold Marsh, Madison, gave an address on "Medical Impressions of Vienna"; Dr. Ira Sisk, Madison, spoke on "Some Problems in Urology"; Dr. O. B. Nugent, Chicago, read a paper on "Cataracts." The doctor spent last winter in India and spoke of the prevalence of cataract among the natives and conditions prevailing under which operations are done. Dr. J. W. Gale, Madison, spoke on "Cancer of the Breast." After a social hour dinner was served in the dining room by the Episcopal Ladies' Guild. Toasts and after-dinner speeches, with Dr. J. C. Doolittle as toastmaster, finished this interesting and enjoyable program. *M. B. G.*

LA CROSSE

The regular monthly meeting of the La Crosse County Medical Society was held on October 12th. A motion was made by Dr. Edward Evans and seconded by Dr. Matt McGarty that the officers of the society arrange a meeting for the purpose of demonstrating periodical health examinations. The motion was unanimously carried. Dr. Wm. E. Bannen gave an interesting talk on "Ureteral Obstructions," illustrated by lantern slides. A discussion followed.

The next meeting was held on November 9th. Dr. S Franklin Adams of the Mayo Clinic spoke on "Diabetes Mellitus." *N. P. A.*

LANGLADE

The annual meeting of the Langlade County Medical Society was held at the Butterfield Hotel at Antigo on October 26th. A fine chicken dinner was served at six-fifteen, after which the meeting was called to order by the president, Dr. M. J. Donohue. The election of officers resulted as follows: President, Dr. M. J. Donohue; Vice President, Dr. E. F. Dorzeski; Secretary and Treasurer, Dr. J. C. Wright. Dr. Wright was chosen delegate to the state meeting and Dr. J. W. Lambert, alternate.

Following the business meeting the president called on Mr. George Crownhart, secretary of the State Society, who spoke on the importance of the county medical society to the State Medical Society and told of some of the activities of the State Society. Dr. J. W. Gale, Madison, was next on the program, his subject being "Carcinoma of the Breast." Dr. Elmer Sevringhaus, Madison, gave an interesting talk on "Diets of Interest to the General Practitioner." Discussion followed. The meeting was pronounced one of the best the society has had for many years. *J. C. W.*

MARATHON

The members of the Marathon County Medical Society met at the Wausau Club on October 26th. A dinner, complimentary to the older men of the society, was

served at six-thirty. An interesting program was presented in the nature of the early history of medicine in Marathon County. Dr. S. M. B. Smith was the first called upon and this address was followed by talks by Dr. D. T. Jones and Dr. A. B. Rosenberry. Dr. Joseph F. Smith related the history of the organized medical society of the state. Dr. V. E. Eastman, secretary of the society, read the minutes of the first meeting of the Marathon County Medical Society which was held in October of 1903. *V. E. E.*

MARINETTE-FLORENCE

The Marinette-Florence County Medical Society held its regular meeting on Thursday evening, October 27th. Following a dinner at the Marinette Hotel, Dr. A. T. Nadeau gave a report of the Clinical Congress at Detroit. Dr. H. F. Schroeder related the interesting incidents of the Interstate meeting at Kansas City. Dr. W. E. Leaper of Green Bay presented a paper on "Indications for Cesarean Section." Dr. G. R. Duer, delegate to our state meeting, told in detail of the meeting at Eau Claire. Dr. T. J. Redelings, as councilor of the Eighth District, spoke on "The New Picric Acid Treatment of Burns."

The society met again on Thursday evening of November 10th and enjoyed an interesting program. Dr. John Kaye, Menominee, Michigan, presented reports of two "Neurological Cases." Dr. Calvin R. Ellwood, also of Menominee, discussed an interesting eye case. Dr. Robert Burns of the University read a paper on "Osteomyelitis" and Dr. J. W. Gale, University of Wisconsin, spoke on "Carcinoma of the Breast."

It being the annual meeting of the society, the following officers were elected: Dr. T. J. Redelings, president; Dr. H. F. Schroeder, vice president; Dr. M. D. Bird, secretary; Dr. S. Berglund, Dr. M. D. Bird, and Dr. J. W. Boren, censors; Dr. G. R. Duer, delegate, and Dr. J. V. May, alternate. *M. D. B.*

MILWAUKEE

"The Use of Long Machine Screws in the Treatment of Fractures, Osteotomies, and Certain Joint Resections" was the subject of the paper presented by Dr. John O. Dieterle at the meeting of the Milwaukee County Medical Society on November 11th. Dr. Louis M. Warfield spoke on "Some Remarks on Hypothyroidism," and Dr. Carl Henry Davis on "Management of Labor." The latter was illustrated by lantern slides.

The Committee on Public Policy and Legislation, Dr. John J. McGovern, chairman, made its report on the teaching of physiology in the schools. *E. L. T.*

OUTAGAMIE

About seventy members and guests of the Outagamie County Medical Society, and from the surrounding territory, attended an interesting meeting of the society at Hotel Northern, Appleton, on Tuesday evening, October 25th. Dr. Harry B. Cluver and Dr. Russell D. Herrold, both of Chicago, spoke on "Bladder Conditions." *C. D. N.*

PIERCE-ST. CROIX

On Wednesday evening, November 16th, the Pierce-St. Croix Counties Medical Society held their meeting, following a roast duck dinner at Hotel Beebe, New Richmond.

At the scientific meeting Dr. Philip Greene, associate professor of surgery at the University of Wisconsin, gave a paper on "Non-surgical Treatment of Gynecology with Particular Reference to Backache." At the business meeting Dr. J. Travenick, who is now associated with Dr. Dill at Prescott, was elected to membership in the society.

The next meeting of the society will be held at Spring Valley on December 15th. This meeting will be a very short scientific program followed by a Christmas stag party. *J. W. P.*

PRICE-TAYLOR

The regular annual meeting of the Price-Taylor County Medical Society was held at Medford on Tuesday, November 8th. Dr. E. A. Riley was chosen president for the year 1928; Dr. J. D. Leahy, secretary; Dr. F. W. Mitchell, vice president; Dr. W. P. Sperry, Dr. F. W. Mitchell and Dr. Ray Nystrum, censors; Dr. E. A. Riley, delegate, and Dr. J. D. Leahy, alternate. *J. D. L.*

RACINE

The regular meeting of the Racine County Medical Society was held at St. Mary's Hospital, Racine, on October 27th at 3:30 p. m. Dr. Frederick Gaenslen, Milwaukee, addressed the members on "Fractures," and Dr. R. M. Kurten, Racine, presented a paper on "Colloidal Lead in the Treatment of Cancer." A business session preceded the scientific program. *S. J.*

WASHINGTON-OZAUKEE

The quarterly meeting of the Washington-Ozaukee County Medical Society was held on November 1st at the Schultz Hotel, Kewaskum, where the members and guests were entertained at a banquet at six-thirty. Dr. D. W. Crile of Chicago, Dr. A. W. Rogers, State Society president, and Mr. J. G. Crownhart, state secretary, addressed the meeting. Dr. Crile talked on "Fractures," which was illustrated with chalk diagrams. Mr. Crownhart spoke briefly on the work of the State Society and Dr. Rogers prefaced his address with a talk on the value of the county medical society and pointed out the fact that it was the basic unit upon which the larger structures of the state and national organizations are erected. He then discussed points in differential diagnosis in the type of mental and nervous cases most frequently seen by the general practitioner. *A. H. H.*

FIRST COUNCILOR DISTRICT

The second annual meeting of the First Councilor District of the Wisconsin State Medical Society was held on Tuesday, October 11th, at the Oconomowoc Health Resort, Oconomowoc.

Dr. A. W. Rogers, councilor and president of the First District, presided officially and also as host to the meeting.

The scientific program began at three o'clock in the afternoon with a most entertaining and lucid address by Dr. L. G. Rowntree on "Recent Developments in Our Knowledge of the Liver," in which he portrayed the ever increasing value of knowledge concerning functional

activity for the sake of more efficient prognosis and diagnosis. Dr. L. M. Warfield opened the discussion with a plea for balanced values on laboratory and physical findings in obtaining the same end.

An address on "Headache" by Dr. B. B. Rowley was resplendent with practical facts concerning the anatomical interrelationship of the various cranial nerves to the fifth nerve, thereby offering explanations for the occurrence of this symptom in the presence of lesions otherwise believed to be of no influence. Dr. H. W. Powers opened the discussion and enlarged upon the facts presented.

Dr. F. J. Gaenslen addressed the meeting on the subject of "Fractures," defining and demonstrating some of the simple and effective modes of dealing with the common types encountered by the general practitioner. He emphasized the importance of utilizing physical diagnosis with a view to good functional results rather than depending entirely upon the x-ray with a view to attaining more perfect anatomical results.

The meeting was adjourned for the banquet, the fineness of which can best be defined as a consistent characteristic of our host.

At the close of the banquet Dr. C. R. Bardeen talked to us, "On Keeping Up to Date." His talk was a delightful reminder of the many methods which we have at our finger tips for keeping abreast of the ever changing environment in which the practicing physician finds himself. He made us feel that to be "too busy" to make use of them was in reality careless neglect of duty. We were enthused over the witty and humorous manner of this practised after-dinner speaker.

The names of Dr. H. O. Caswell, Fort Atkinson, and J. F. Wilkinson, Oconomowoc, for president and secretary of the district for the coming year were presented by the nominating committee and approved by the meeting. *J. F. W.*

THIRD COUNCILOR DISTRICT

Members of the Third Councilor District held their annual meeting in Madison on November 9th and 10th in conjunction with a meeting of the American College of Surgeons.

Announcement of a memorial foundation to the late Dr. Albert Ochsner, a University of Wisconsin alumnus and eminent among Wisconsin scientists, was made before the meeting by Dr. Bowman C. Crowell and Angus Hibbard, president of the Illinois Bell Telephone Company and chairman of the foundation committee.

The foundation will use a fund of $300,000 in clinical research and in the compilation of scientific data, according to Dr. Crowell, director of this department of the college. "The Ochsner foundation will constitute a clearing house for surgical knowledge," he stated in an address at the Loraine Hotel during the session.

This convention brought to Madison the leading surgeons of the state of Wisconsin and Illinois, together with the heads of all the hospitals in the state, and outstanding public health officials. Dr. Corydon G. Dwight was chairman of the local committee on arrangements, Dr. Albert Tormey, secretary, and Dr. C. A. Harper is councilor for the Third District.

NINTH COUNCILOR DISTRICT

Stevens Point was selected as the place for the spring meeting of the Ninth Councilor District Medical Society at its session at Marshfield on Thursday, October 27th. The attendance was large, totaling about seventy physicians from the counties of Clark, Green Lake, Waushara, Adams, Lincoln, Marathon, Portage, Waupaca and Wood.

The following program had been arranged for the meeting, which began its session at two o'clock at St. Joseph's Hospital, Marshfield: "Clinical Demonstration of a Case of Pernicious Anemia, with Special Reference to the Dietary Treatment," Dr. Wm. S. Middleton, Madison; "The Medical Profession and the Industrial Commission," Mr. R. G. Knutson, Madison; "The Malignant Tumors of the Kidney, with Particular Reference to the So-Called Hypernephroma of the Kidney," Dr. Edward L. Miloslavich, Marquette University, Milwaukee.

After the conclusion of the afternoon program the visitors were entertained at a banquet in the nurses' home at the hospital. At seven-thirty Dr. Wm. S. Middleton presented an interesting paper on "The Management of Cardiac Decompensation" and Dr. Joseph S. Evans, of the University, spoke on "Hypertension." *J. F. S.*

GREEN BAY ACADEMY

The meeting of the Green Bay Academy of Medicine was held at St. Vincent's Hospital, Green Bay, on November 9th. Dr. Robert Cowles presented a paper on "Thymus Gland Disturbance." The subject was discussed by Dr. E. S. Schmidt and Dr. V. J. Hittner. *O. A. S.*

MILWAUKEE ACADEMY

Dr. J. A. E. Eyster and Dr. Wm. S. Middleton, of the University of Wisconsin, addressed the members of the Milwaukee Academy of Medicine during the latter part of October. The subject of Dr. Eyster's paper was "Factors Underlying Cardiac Hypertrophy" and Dr. Middleton spoke on "Clinical Application of Venous Pressure."

At the Academy meeting on November 8th, Dr. F. D. Murphy, Milwaukee, presented a paper on "Chronic Nephritis With and Without Edema," and Dr. George O. Guy, Milwaukee, discussed a report on "Tissue Cultures from the Laboratory of Columbia Hospital."

On Tuesday, November 22nd, Dr. Franklin C. McLean, professor of medicine, University of Chicago, spoke on "Some Problems in Edema." Drs. F. E. Walbridge, Stevens Point, F. C. Studley, Milwaukee, A. W. Rogers, Oconomowoc, and L. M. Warfield, Milwaukee, have presented the Academy Library with a number of valuable books. *D. E. W. W.*

MILWAUKEE OTO-OPHTHALMIC

Dr. Arthur M. Alden, St. Louis, Mo., presented an interesting paper on "Mastoiditis in Infants" at the monthly meeting of the Milwaukee Oto-Ophthalmic Society at the University Club on November 15th. A dinner at the Club preceded the program. *E. R. R.*

UNIVERSITY OF WISCONSIN

The University of Wisconsin Medical Society held its second meeting of the year in Room 119, Science Hall, at 8:00 p. m., November 2nd.

Dr. I. Snapper, professor of pharmacology and general pathology of the University of Amsterdam, addressed the society on "The Non-Excretory Functions of the Kidney." Perfusion experiments on the isolated kidneys of both human beings and dogs were described, which indicated that the organs have certain functions other than the excretion of urine: (1) the synthesis of hippuric acid, and of phenaceturic acid; (2) the oxidation of acetone bodies formed in normal metabolism; (3) the oxidation of aromatic fatty acids. Although these properties are distinct from that of excretion of urine, the kidney may suffer a simultaneous impairment of both excretory and non-excretory functions. This is probably the condition in those cases of diabetic coma which fail to respond to insulin. *H. W. C.*

WISCONSIN ANTI-TUBERCULOSIS

Re-launching the fight against tuberculosis and planning a more effective campaign against heart disease, the nineteenth annual meeting of the Wisconsin Anti-Tuberculosis Association was held at the Health Service Building, October 31st and November 1st. Two hundred and fifty persons from all sections of the state attended this two-day meeting, which was devoted to a discussion of Wisconsin's public health problems.

At the general sessions of the meeting speakers of state and national importance made talks along the following lines: the sanatorium situation in Wisconsin; a health program for rural and urban schools; the value of periodical physical examinations for industrial workers; and the various aspects of tuberculosis and heart disease. Among the speakers at these general sessions were: Miss Maybell Bush, state department of school instruction; Dr. A. W. Rogers, president of the State Medical Society; Dr. W. W. Bauer, Racine commissioner of health; Dr. Charles Stoddard, Milwaukee; and Mrs. George Zachow, president State Parent-Teacher Association.

Dr. Herman N. Bundesen, commissioner of health, Chicago, was the principal speaker at the annual dinner of the association held at the Hotel Astor, October 31st. The urging of segregation of children from tuberculous parents was the keynote of Dr. Bundesen's talk. He said, "We must separate children from contacts with tuberculosis in homes where the disease exists. It is nothing short of murder to allow children to be exposed to open cases of tuberculosis."

At the second day of the meeting there were three group conferences held. These were for sanatorium superintendents, nurses, physicians and trustees; for social workers and public health nurses and for seal sale managers. A feature of the sanatorium conference was the commemoration of the opening of the State Tuberculosis Sanatorium twenty years ago. Dr. J. W. Coon, the second superintendent of the institution; Miss L. Dietrichson, first nurse at the sanatorium; Dr. L. W. Dudley, present superintendent; and Col. John Hannon, State Board of Control, were among those who spoke at this conference. James E. Clark, Greenleaf, the oldest living ex-patient of the institution, also attended the meeting.

The business session of the annual meeting resulted in the following officers being re-elected for another year: H. H. Jacobs, president; Dr. Charles Stoddard, first vice-president; Mrs. George Waller, Burlington, second vice-president; Dr. J. Gurney Taylor, recording secretary; and Howard Greene, treasurer. Charles Gleason, Manitowoc, was elected to the board of directors to fill the unexpired term ending in 1929 of the late Dr. Frank Brockway, Oshkosh. Others elected to the board of directors, their terms to expire in 1930, were: F. S. Hyer, Whitewater; H. H. Jacobs, Milwaukee; Otto Mueller, Wausau; Howard Greene, Milwaukee; John Kuypers, DePere; Dean Chester Snell, Madison; and Dr. R. E. Mitchell, Eau Claire.

NEWS ITEMS AND PERSONALS

Dr. S. Plahner, Milwaukee, returned recently from Vienna, where he attended the Congress of Psychiatrists and Neurologists and the International Congress of Individual Psychologists. He worked with Dr. Alfred Adler during his stay abroad. Dr. Plahner is giving private courses in Milwaukee on individual psychological treatment of neuroses for physicians.

—△—

Dr. C. J. Ryan, formerly of Kilbourn, has purchased the practice of Dr. George D. Beech of Adams. Dr. Ryan is a graduate of Marquette University School of Medicine, 1925.

—△—

"Studies in Drug Tolerance" was the subject of a paper given by Dr. Arthur S. Loevenhart, of the university pharmacology and toxicology department, at the dedication of new clinics, medical laboratories, and the Albert Billings Memorial Hospital of the University of Chicago on October 31st and November 1st.

Dr. C. R. Bardeen, dean of the Wisconsin University Medical School, represented both the medical school and the university at the convocation and dedicatory exercises.

—△—

At the meeting of the La Crosse County Historical Society held recently at the La Crosse State Teachers' College, the early history of medical practice was reviewed by Dr. D. S. MacArthur, whose father, Dr. P. S. MacArthur, was a pioneer practitioner of that county. Dr. MacArthur presented the society with several gifts which included: an internal revenue license granted to Dr. P. S. MacArthur on May 1, 1865, an old-fashioned stethoscope, a dentist's turnkey and a physician's cupping instrument of old design.

—△—

Dr. Leo Moriarity, Two Rivers, has returned from an eight weeks trip to Europe, where he attended the Legion convention at Paris, visited Rome, and also attended medical clinics in Berlin and Vienna.

—△—

The need for parents to inform themselves properly on the question of health and disease, especially as it applies to their children, was stressed by Dr. S. H. Lippitt, Milwaukee, in his talk before the mothercraft class at the maternity center. The class is conducted under the auspices of the Maternity Hospital and Dispensary Association.

Dr. B. E. Hedding, a member of the medical staff of the Wisconsin Anti-Tuberculosis Association, spoke before a lay audience at the Chippewa Falls high school auditorium on October 19th. The subject of his talk was the need of a tuberculosis sanatorium for Chippewa county.

—△—

Members of the Beloit Physicians' and Surgeons' Club attended the Lee County Medical Society meeting at the Dixon State Hospital, Dixon, Ill., on October 26th. Dr. Alexander S. Herschfield, newly appointed Illinois state alienist, was honored at dinner on this occasion.

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Dr. and Mrs. E. C. Cary have returned to Reedsville after an extensive trip abroad. They sailed for Europe on September 8th with the American Legion.

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At a meeting of the governing council of the American Public Health Association held at Cincinnati, Ohio, on October 20th, a number of health workers were elected to fellowship in the association. Fellowship requirements are five years or more exclusive service in public health, two years or more of membership in the American Public Health Association, and the performance of public health work of more than ordinary merit.

Wisconsin men thus honored by the association include: Dr. E. V. Brumbaugh, deputy health commissioner of Milwaukee; Dr. George P. Barth, school physician of Milwaukee, and Dr. W. W. Bauer, commissioner of health, Racine.

—△—

Dr. George D. Beech of Adams has sold his practice to Dr. C. J. Ryan, formerly of Kilbourn. Dr. Beech will reside at Rio Hondo, Cameron County, Texas.

—△—

Speaking on "School Physicians from the Viewpoint of the Health Officer," Dr. G. Windesheim, Kenosha director of public health, addressed more than three hundred delegates Monday, October 17th, at the annual convention of the American Public Health Association held at Cincinnati.

The address was part of a program to institute a new section in the association, the school physicians section, and Dr. Windesheim was requested to speak on this subject because of his knowledge of the problems presented in this particular line.

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Dr. J. E. Donnell has disposed of his practice at Cuba City and is taking a course in ophthalmology at the Graduate School of Medicine of the University of Pennsylvania.

—△—

Prof. M. F. Guyer, professor of zoology at the University of Wisconsin and secretary of the Basic Science Board, attended a meeting of the commission on medical education at Montreal, Canada, during the latter part of October. Prof. Guyer was one of six representative American scientists to attend the meeting. The commission is further composed of six university presidents and six eminent medical men and its object is to study medical and pre-medical education through research and interview.

Two hundred guests attended the formal dinner-dance given at the Loraine Hotel, Madison, by Dr. and Mrs. W. J. Bleckwenn and Dr. and Mrs. W. F. Lorenz in honor of Dr. and Mrs. H. H. Reese. The Reeses, who were married last spring, spent a part of the summer in Europe. Dr. Reese is senior physician at the Wisconsin Psychiatric Institute.

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Dr. Thomas Hall Shastid's work of many years on the evolution of the eye is summed up in the November number of the Scientific American by W. E. Bailey in an article entitled "Evolution of the Human Eye." The article is profusely illustrated. Dr. Shastid's home is in Superior and his office at Duluth.

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Following the next meeting of the Board of Medical Examiners, probably in January, Dr. E. L. Belknap will be associated with the Warfield Clinic, Milwaukee.

—△—

Dr. Albert H. Lahmann of Johns Hopkins Hospital is now associated with Dr. C. H. Davis, Milwaukee, in the practice of obstetrics and gynecology.

—△—

Dr. M. D. Bird, Marinette, was elected orator of a newly initiated class of 32nd degree Masons at Milwaukee during November.

—△—

Dr. F. A. Marrs and Dr. G. H. Lawrence of Stevens Point attended the annual convention of American Railway Surgeons which was held at Hotel Sherman, Chicago, the first week of November. Dr. Lawrence presented a paper on "Injuries to the Eyeball."

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Dr. Thomas Lucast of Belle Plaine, Iowa, has established his practice at Birnamwood. Dr. Lucast is a graduate of the Wisconsin College of Physicians and Surgeons, Milwaukee.

—△—

Dr. S. G. Schwarz of the Marshfield Clinic left recently for Vienna, Austria, to spend six months in post-graduate work, specializing in skin diseases and physiotherapy. Dr. Schwarz sailed from New York on a North German Lloyd steamer on Saturday, November 12th, bound for Bremen, whence he goes by rail to Vienna.

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Dr. Leo Voorus, Milwaukee, pleaded guilty to performing an illegal operation, second offense, and was fined $500 in municipal court recently. Judge George H. Shaughnessy ordered revocation of Dr. Voorus' license to practice medicine in Wisconsin.

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Thirty-one counties in the state employ nurses for rural school and community health work. This number does not include Milwaukee county, where the nursing service is chiefly urban.

The counties which employ nurses, according to the state board of health, are: Ashland, Chippewa, Crawford, Columbia, Dane, Grant, Iron, Jackson, Jefferson, Juneau, Kenosha, La Crosse, Langlade, Lincoln, Manitowoc, Marinette, Outagamie, Ozaukee, Racine, Rock, Sauk, She-

boygan, Trempealeau, Vernon, Vilas, Walworth, Washington, Waukesha, Waupaca, Winnebago, and Wood.

—△—

Dr. Charles W. Blanchard, Janesville physician, who was sentenced to a term of four to six years in the state prison at Waupun for performing an illegal operation, has been pardoned by Gov. Fred R. Zimmerman. Dr. Blanchard was sentenced Sept. 4, 1926, by Judge Harry L. Maxfield in municipal court.

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Dr. Nils Omsted returned to his home at Stoughton during the first week in November after being in a Madison hospital for more than a month as the result of injuries received in an automobile accident on September 29th. He is making a gradual recovery.

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Maintaining that mental progress depends on the physical health of a child, Dr. H. C. Johnson, pediatrician, spoke to the opening meeting of the pre-school group of the Lapham district, at Madison, recently. His subject was "Guarding the Health of the Pre-School Child."

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With twenty-two physicians present, Mercy Hospital staff, Janesville, held an interesting meeting at the monthly dinner on November 3rd in the hospital dining room. Dr. Wayne A. Munn, acting president since the death of Dr. F. R. Lintleman, presided. A paper on "Broken Backs—Ten Cases in Janesville and Vicinity" was given by Dr. T. W. Nuzum. Dr. Munn reported an atypical appendicitis case and Dr. Guy C. Waufle discussed the case. Dr. Frank Van Kirk cited an atypical case of the same disease, with Dr. W. T. Clark discussing it.

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Dr. A. A. Pleyte of the Wisconsin Anti-Tuberculosis Association, Milwaukee, spoke before the Kiwanis Club luncheon at Neenah on November 15th. His subject was "Health, a National Asset."

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Dr. S. R. Medley, formerly of Siren, has established his practice at Shell Lake. He is using the former office of Dr. F. O. Risher temporarily.

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Dr. Louis R. Head has been named local Christmas seal sale manager by the Madison Tuberculosis Association. The campaign, which will be carried on Thanksgiving day to Christmas day, is for the purpose of raising funds to carry on the fight against tuberculosis in this state.

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Dr. George P. Barth of the Milwaukee Health Department spoke on "Toxin Anti-toxin and the Schick Test" before the Mothercraft School of the Maternity Hospital and Dispensary Association on November 19th. Dr. Malcolm L. Hipke discussed "Prevention of Tuberculosis in Children."

MARRIAGES

Dr. Emmett Cook, Milwaukee, to Miss Grace K. Roberts, also of this city, on November 12th.

DEATHS

Dr. John M. Beffel, Milwaukee, died suddenly at his office on Saturday, October 22nd. Death was due to a heart ailment of which the doctor was aware, although he had been in good health recently. Dr. Beffel was born in Racine, February 28, 1867, and was graduated from the Northwestern University Medical School in 1898.

The deceased was a captain in the world war, serving two years with the medical corps of the 32nd division and eleven months in France. For years he served as one of the directors of the Wisconsin Anti-Tuberculosis Association. It was due to his suggestion that the Milwaukee Infants' fresh air pavilion was founded in 1910. He also served on the Milwaukee Milk Commission, which brought out certified milk and demanded higher milk standards for the city. In 1910 and 1911 Dr. Beffel made the first detailed statistical study of the problem of infant mortality in Milwaukee, the council creating the child welfare commission, of which he, soon after its organization, became chairman.

Dr. Beffel was a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin and a fellow of the American Medical Association. He is survived by his wife, a son and a daughter.

Dr. Joseph C. Elfers, Sheboygan, died at the Milwaukee Deaconess Hospital on October 31st of bichloride of mercury poisoning. Dr. Elfers was born in Cincinnati in 1859 and was graduated from the Medical College of Ohio in 1890. He had practiced medicine at Sheboygan for thirty-five years and was health commissioner of the city for the past five years. Dr. Elfers and the late Mr. Frank Ira, poor commissioner, left on a trip to Germany the first of July. Neither returned to Sheboygan alive. Mr. Ira died aboard the steamer just after leaving Bremen and Dr. Elfers became ill while accompanying his body to this country.

The deceased was a member of the Sheboygan County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. A foster daughter and a brother survive.

Dr. Dennis J. Hayes, Milwaukee, died Wednesday, November 23rd, at his home after an illness of nearly five years. Dr. Hayes was born in 1854 and was graduated from the Northwestern University School of Medicine in 1879 and later from Rush Medical College, Chicago, in 1903. He was one of the founders of the Wisconsin College of Physicians and Surgeons, which affiliated with Marquette University after the medical school was started there and continued to teach in the Marquette Medical School until 1919.

The deceased was a member of the Milwaukee County Medical Society, the State Medical Society of Wisconsin, the American Medical Association and a Fellow of the American College of Physicians. He served as president of the State Medical Society of Wisconsin in 1918 and has maintained a private practice in Milwaukee for more than thirty-five years. Dr. Hayes is survived by his wife and two daughters.

SOCIETY RECORDS

New Members

Vandandaigne, Isaac, Pulaski.
Galford, G. H., 118 E. Wisconsin St., Neenah
Prehn, Fred, 220½ Third St., Wausau.
Suhr, A. L., 795 48th St., Milwaukee.
Wieder, L. M., 445 Milwaukee St., Milwaukee.
Jenner, J. A., 1514½ Wells St., Milwaukee.
Sullivan, G. A., 2702 Lisbon Ave., Milwaukee.
Pugh, G. J., 190 Villard Ave., North Milwaukee.
Rettig, F. E., 168 Villard Ave., North Milwaukee.
Kretlon, F. A., 483 27th St., Milwaukee.
Ruffalo, A. F., 1010 56th St., Kenosha.
Tauger, V. J., 805 36th St., Milwaukee.
Boley, M. H., 230 Wisconsin Ave., Milwaukee.
Atkinson, H. S., 404 Minahan Bldg., Green Bay.
Weed, L. G., Phelps.
Lindberg, C. O., Grantsburg.
Evenson, E. E., Wittenberg.
McIntyre, G. F., 85 E. Wells St., Milwaukee.
Malnekoff, B. J., 425 E. Water St., Milwaukee.
Rice, R. W., Stevens Point.
Tallmadge, G. K., 141 E. Wisconsin Ave., Milwaukee.

Changes in Address

Beech, Geo. D., Adams, to Rio Hondo, Cameron Co., Texas.
Tuffley, F. S., Boscobel, to First Nat. Bank Bldg., Baraboo.
Ehmer, J. W., Crivitz, to Muscoda.
Donnell, J. E., Cuba City, to 3905 Chestnut St., West Philadelphia, Pa.

CORRESPONDENCE

"ONE OF THE BEST"

Boston, Mass., Oct. 22, 1927.

Mr. J. G. Crownhart, Secretary,
Medical Society of Wisconsin,
153 East Wells Street,
Milwaukee, Wisconsin.

Dear Mr. Crownhart:

Among the exhibit material sent back from the Eau Claire meeting we found two of the Mellin's Food memorandum books which we made up for the meeting. Apparently these got packed in the material through error. Believing you can make use of these we are passing them along to you.

Both Mr. Robbins and Mr. Hazeltine gave us a most favorable report of this year's meeting and appreciate very much the attention given them by yourself. We can say that we always look forward to the Wisconsin meeting as one of the best state meetings we attend.

Very sincerely yours,
Mellin's Food Company.
Howard Goodwin.

A. M. A. OF BERLIN

Dear Sir:

The numbers of Americans coming to Berlin for the study of medicine and for postgraduate work in the clinics and laboratories have prompted the reorganization of the American Medical Association of Berlin, which formerly rendered such valuable service to American medical men, in order that some competent central bureau of information be available. The American Medical Association gladly furnishes information on any subject connected with the study of medicine and allied sciences in Berlin, including cost of living, etc.

Will you kindly bring the fact of the Association's existence to the attention of the members of your society? For this purpose a display card for your bulletin board is enclosed.

Yours truly,
American Medical Association of Berlin.
By A. A. Goldbloom.

Berlin N. W. 6, Luisenplatz 2-4.

LIABILITY OF ATHLETIC COACH

Mr. J. G. Crownhart,
153 Oneida Street,
Milwaukee, Wis.

Dear George:

You addressed to me an inquiry as to the liability of a school district or of an athletic coach where the coach gives first aid to a schoolboy hurt in athletics.

If the coach was acting within the scope of his employment, the school district would be liable unless some other rule of law establishes non-liability or the liability was waived or was nullified by contributory negligence. It is the rule that the municipality (and a school district is in this sense a municipality) is not liable for the neglect of its employee in the performance of a governmental function. See cases cited in this letter.

Conducting a school is a governmental function.

Folk v. City of Milwaukee, 108 Wis. 359,
Juul v. School District, 168 Wis. 111.

Also conducting a playground or a bathing-beach is a governmental function.

Bernstein v. Milwaukee, 158 Wis. 576,
Nemet v. Kenosha, 169 Wis. 379.

A related case is also that of the neglect of a health officer; for this the city is not liable, for the same reason.

Kempster v. Milwaukee, 103 Wis. 421.

Perhaps a somewhat analogous case is that of *Morrison v. Fisher*, 160 Wis. 621, in which it was held that the giving of entertainments, such as an airplane flight, in connection with the state fair, was a part of the state fair, which in the same case was held to be a governmental function.

It is therefore my opinion that the school district would not be liable no matter what the neglect of the coach, because of the governmental function rule.

If the coach was acting outside the scope of his employment, he would be liable for negligence in the performance of any duty he assumed; just what duty he assumed would be a question of fact to be determined from all the circumstances in the particular case. If the coach was acting within the scope of his employment and, therefore, in the performance of a governmental function, he would still be liable if the duty were a ministerial one; and I am of the opinion that if this were a

part of his duties, it would be a ministerial duty. The coach might, of course, be discharged from liability by waiver or by contributory negligence.

I doubt that obligation would rest upon a coach to discover anything more than what would be apparent to the layman, or to advise the boy to seek medical attention, unless, perhaps, it was obvious that he had sustained an injury requiring medical attention. If no obligation was assumed by or rested upon him, no neglect could be predicated upon his failure to act. It might be, however, that a duty would rest upon him to make a sufficient examination to ascertain those things which a layman would recognize in the exercise of ordinary care.

Without some court decision upon the extent of the duty to the boy, I would not want to render an opinion as to the liability of the coach without a complete statement of facts in a particular case.

I do not think the coach would be liable for practicing medicine without a license, because of section 147.19 (1), the exception of "treatment rendered in an emergency," unless he went beyond treatment in an emergency and attempted to diagnose and advise more than was necessary for first aid, and it would probably require an extreme case to secure a jury finding of that nature.

Yours truly,
F. M. WYLIE, *Counsel.*

APPRECIATE JOURNAL

KAPPA
of
ALPHA KAPPA KAPPA
Milwaukee, Wisconsin

2524 Cedar Street,
November 11, 1927

Managing Editor,
Wisconsin Med. Journal,
Dear Mr. Crownhart:

Members of Alpha Kappa Kappa medical fraternity wish to thank you most heartily for the splendid courtesy shown us by mailing issues of the Wisconsin Medical Journal.*

We find the Journal a valuable asset to our library, and look forward to its monthly issuance.

Most sincerely,
ARCHIE M. KADOW,
Corresponding Sec't.

P. S.—Will you kindly note change of address.

CONSTRUCTIVE CRITICISM

Oshkosh, Wis.,
November 11, 1927

J. G. Crownhart,
153 E. Wells St.,
Milwaukee, Wis.
My dear George:

In view of the fact that Dr. Louis Warfield's "Diagnostic Problems" are well worth publishing and well worth perusal by the Journal readers, I would suggest that this contribution be so placed that it will be unnecessary to break its continuity with part of it many pages distant from the context, as for example in the November number, among the advertisements. This location may be beneficial for the ads, but discourages study of the doctor's cases.

Very sincerely yours,
FGC:JW GREGORY CONNELL.

*The Journal is presented to all medical fraternity chapters in the state.—Editor's Note.

DEATH OF DR. HAYES

Mrs. D. J. Hayes, November 28, 1927.
528 Stowell Ave.,
Milwaukee, Wis.
Dear Mrs. Hayes:

The news of the death of your husband, a former president of this society, will be received with a keen sense of loss by the profession of this state. Dr. Hayes, by his genial personality and distinct contributions to medical organization was known throughout Wisconsin. As I have traveled the state for the past few years the most frequent question I have had to answer was that inquiring about him.

It is apparent to me that none knew him except to hold him in affectionate high esteem and in his death the profession of Wisconsin has lost one of its front rank men. Writing for the 2,100 members of this society, may I express to you, Mrs. Hayes, in their behalf, deepest and most sincere sympathies.

Sincerely yours,
J. G. CROWNHART,
JGC:J Secretary.

SURVEY OF NURSES

Madison, Wis., Nov. 15, 1927.

Mr. Geo. Crownhart,
153 Oneida Street,
Milwaukee, Wisconsin.
My dear Mr. Crownhart:

We are enclosing an analysis which we wrote you we were making taken from our cards of re-registration for the year 1927, which will tell you how many nurses we have in Wisconsin and what they are doing, as nearly as it was possible to obtain. We expect to continue this survey next year and at that time to have more complete information.

Very truly yours,
ADDA ELDREDGE, R. N.,
Director, Bureau of Nursing Education.

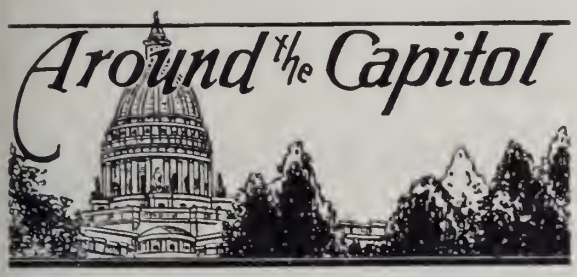
Analysis of Fields of Nursing
As of Sept. 15, 1927

	1924	1925	1926	1927
Public Health	292	314	364	345
Private Duty	706	790	863	747
Sisters	206	213	226	226
Institutional	473	576	631	472
Out of State	114	140	179	165
Government	17	16	20	12
Other Fields	66	77	82	75
Not Practicing	67	77	92	61
Undecided	...	...	...	637
	1941	2203	2457	2740

Two branches, part of year for each (mostly Private Duty and Institutional)	88	103	166	18
Priv. Duty, Inst., and Other Fields	1	...	...	...
Pub. H., Priv. Duty and Inst.	...	4	...	...
Inst., Gov't., and Other Fields	...	1	...	...
Pub H., Priv. D., and Inst.	...	...	4	...
Pub. H., Priv. D., and Other Fields	...	...	1	...
Total No. from which information was received	2030	2311	2628	2758
*No information	628	461	223	316
Total No. of Registered Nurses	2658	2772	2851	3074

The above data was taken from the re-registration cards for 1927 and shows the distribution of the nurses for the last four years.

*For 1924, 1925 and 1926 the number represents those nurses who were not practicing in Wisconsin in 1927 and therefore did not fill out the re-registration card. The 316 for 1927 represents the nurses newly registered during the year 1927.



Lumpy jaw, a disease among cattle, may be communicated to humans and when the disease is contracted in the course of employment, compensation insurance should be awarded. This was a decision of the supreme court in a recent industrial commission case.

The court holds that as there was evidence before the commission the germ causing death from lumpy jaw does not die with the death of an animal but remains imbedded in the hide of the animal and could pass from the hide to the hands of a man handling the hide and then through contact with his mouth into his system, the commission had evidence upon which to base a finding for an award, and states the rule governing the commission as follows: "Under such circumstances, the industrial commission or the court can base its findings upon a preponderance of possibilities, or of the inference that can be drawn from established facts."

* * *

The State Board of Health took steps to transport a case of leprosy from Wisconsin to the United States leprosarium at Carville, La. The removal was made safely under the chaperonage of a physician from the vicinity of the afflicted man's home. This case was discovered last August on a farm in Marathon county, a few miles from Birnamwood. Segregation was instituted and the patient's family and farm cared for by neighbors and the town board. By the agency of new treatment measures, hopes are held that this Wisconsin victim of the disease may be restored to his family cured in the course of a few years.

A physician duly licensed in another state is not required to be licensed in Wisconsin for the purpose of practicing when he is in actual consultation with a resident licensed practitioner, was the opinion of the Attorney General to Bruce M. Blum, district attorney of Green county.

* * *

The old age pension system is the most economical method yet devised to care for the poor, according to A. E. Garey of the state civil service commission, who has compiled statistics to bear out this contention. Under the old age pension system old persons who would ordinarily go to the poorhouse receive one dollar a day or less, according to their needs, from the county for support and maintenance.

"Three counties—La Crosse, Outagamie and Sawyer—have already advocated the old age pension system and Milwaukee, Dodge and Wood counties are considering the plan at present," said Mr. Garey. "The average cost of supporting one person by this system is $221 a year. The average yearly cost of maintaining one person in a county poorhouse is $296.40. The outdoor poor relief method costs the county $286 a year for each person."

* * *

The new Wisconsin conservation commission is considering many possible changes in policies that will be worked out in the next few months. One question to be decided is whether game wardens should wear uniforms and serve as an incentive to law observance backed with the same reasoning on which city policemen are made easily distinguishable. There is much objection to this plan, however, even on the commission. Another problem that the commission is working on is the matter of carp seining. There are some advocates of having the state take over this work so that the state would have all rough fish profits and at the same time could foster a more intense plan of rough fish eradication. The conservation commission has formally declared Horicon marsh a wild life refuge and hunting, trapping and fishing on the marsh are now forbidden. Suit is being brought, however, to test the validity of the act to reflood Horicon marsh and Attorney General John Reynolds has held that the validity of the new refuge law is at least doubtful.

* * *

Dunn county has been advised by the attorney general that members of the county board of health serve without compensation. There is no specific statute under which payments for the service may be made. The opinion declares:

"While it seems a hardship it is clear that this committee takes office without salary and no assurance that it may receive reimbursement for traveling expenses, although business judgment should, in most cases, so require. I can only advise, therefore, that since the statutes make no provision for payment for their services or expenses necessarily incurred in performing their functions, that the county board may not provide by resolution therefor."

* * *

Announcement is made by the State Highway Commission that the next big problem it will tackle is the elimination of the dust nuisance on the public highways.

H. J. Kuelling, state highway engineer, has sent a letter to all county commissioners asking that the problem be taken up in each county this winter and the matter be given consideration in awarding maintenance highway contracts. It has frequently been pointed out that the use of highways for pleasure purposes is destroyed by dusty roads and that in many instances a proper regard for maintenance would minimize the evils complained.

* * *

Every person who drives an automobile in Wisconsin, non-residents excepted, after January 1, must have a driver's license. Every owner of a car receives his license free on filing the proper information blank, which is furnished upon request by the office of the secretary of state, Madison. All others than the owner must also have a license, which is obtained by filing the blank with a fee of twenty-five cents. So many applications are being received that it requires over 100 stenographers to answer the letters. It is estimated that by the time the spring driving season opens 2,000,000 driver's licenses will have been issued. These licenses are revokable by the courts for negligent driving. Persons operating a car without a driver's license subject themselves to heavy penalty.

* * *

Hippers won only a partial victory recently when the supreme court determined that justices of the peace are without authority to issue warrants for the search of persons. The decision was in the John Kriegbaum case, brought down from Marquette county.

Speaking of authority granted such searches, the opinion says:

"The law grants no authority to issue a warrant for the search of a person. The authority conferred is confined to the search of a particular house or place. When the property or thing sought is alleged to be concealed we think it would be an unreasonable conviction to hold that the legislature intended to confer the power to direct the search to the person of a human being when it granted the power to issue warrants to search the place where it is alleged that property is concealed.

"We express no opinion as to the power of a court of general jurisdiction to issue a warrant to search the person," the court also says. So there is still a possible peril confronting the pocket flask.

* * *

A survey conducted by the state board of control indicates there are upwards of 800 cases of encephalitis in the state. Recommendation has been made by the board that a separate building should be erected at one of the state hospitals for the study and treatment of such cases. Information on the disease is being gathered by Dr. W. F. Lorenz, Wisconsin General Hospital, where many cases have been sent by counties for care during the past year.

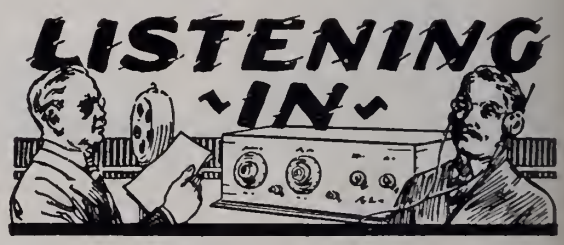
* * *

Wisconsin folks are habitual readers if one is to judge from the demands they are making on the Wisconsin traveling library. It is not unusual for the library to receive 300 requests for books on a Monday morning, and a goodly number of the 300 will be from farm families. During the past year 54,000 volumes were sent out by mail direct to the readers. A large percentage of that number was farm readers, for in towns having libraries no books are sent direct to the reader, but are sent to the local library. The library shipped and mailed a total of 166,000 volumes to Wisconsin people during the year.

* * *

Wisconsin has 620 teachers drawing pensions under its teacher's retirement law, according to figures given out by R. E. Loveland, secretary of the state retirement division of the teachers' pension bureau. Both the state and the teachers contribute to the fund. Of the 620 on pension, two are retired from the university, 18 from the normal schools and 600 from the public schools. The state system is independent of the Milwaukee system. A total of 2,175 instructors are paying into the pension fund at the present time, 500 from the university, 475 from the normals and 1,200 from the public schools. W. A. Cochrane of Delavan has the distinction of being the oldest male pensioner. Mr. Cochrane is 85 and he taught in the deaf and dumb school at Delavan for many years.

J. Q. Emery of Madison, former dairy and food commissioner of Wisconsin and again now connected with that department, is one of the oldest teachers receiving a pension. He is 84 and after resigning his office in the capitol taught one year in the Fort Atkinson high school in order to complete his term as an instructor and become eligible for a pension.



DO NOT FORGET

On January first the new automobile drivers' license law is effective. Do not fail to mail your application at once. Address, Drivers' License Division, Secretary of State, Madison.

Members will also be interested to know that the new law makes mandatory the windshield wiper and prohibits the use of windshield posters or stickers except such as may be officially approved.

$6 TO $60

Dr. J. N. Davis, Secretary of the Idaho State Medical Society reports in a visit that his Society has just approved an increase in dues from $6 a year to $60 that the State Society may employ a full time secretary and embark upon a program of service to the members. The new high figure is made necessary by the fact that the Idaho Society has but 230 odd members.

LETTERS APPRECIATED

From time to time individual members report to the Secretary what appears to be a law violation or send in the advertising material of some quack. Such letters and material are indeed appreciated. It is not always possible to secure the action desired but the reports and investigations are always productive of invaluable material for the files which, at some future time, may be used most effectively.

"AS A LEADING CITIZEN"

How often that flattering phrase is used to secure your endorsement for this or that with a set of something at cost in exchange! Not a week passes but what your Secretary is so solicited. The name of a physician on an order blank has a definite value to a solicitor. Watch that you do not so lend your name to unworthy projects.

LEADERS

"Illinois, Texas and Wisconsin apparently are the leaders in lay education." Report of Committee, Pennsylvania State Medical Society.

DOLLARS AND CENTS

The first of January will see the first Medical Blue Book in the mails for each member in good standing. The compilation and digest of laws and rulings affecting physicians and the practice of medicine in Wisconsin will be, we think, of inestimable value to each member.

When you receive your copy turn to the pages describing depreciations and deductions allowed physicians under the income tax laws. We venture to say that each member can save his Society dues for 1928 right in those pages. Watch for your copy.

Tuberculosis Increases in Wisconsin; Association Plans Extended Work for 1928

By MRS. RUTH MacMILLIN
Wisconsin Anti-Tuberculosis Assn.,
Milwaukee

Thanksgiving day marked for the twentieth time the opening of the annual Christmas seal campaign to raise funds for carrying on Wisconsin's organized fight against tuberculosis. Forty-two million little health stickers have been distributed throughout the state for sale, and upon the sum raised in this way will depend the 1928 program of the Wisconsin Anti-Tuberculosis Association.

Prevention and the periodic physical examination have been keynote messages spread into every nook and corner of the state by the Association during the past year, and these two objectives are again to be emphasized in next year's program. The periodic physical examination as a means of early discovery in all diseases is stressed by the Association not only at the hundreds of free chest clinics it conducts each year, but in all its health literature and in a series of posters which are exhibited among all kinds of civic groups both in Milwaukee and throughout the state.

During the past year the Association conducted 1,921 clinics at which nearly 100,000 persons were examined. While tuberculosis was found in only about 12 per cent of these patients, many other defects were discovered, and whenever any kind of disease or defects were found, the patients were urged to have the family physician follow up these conditions.

The Wisconsin Anti-Tuberculosis Association is an educational institution whose purpose is to wage the fight against tuberculosis by teaching the lay public how the disease may be prevented and that it may be cured. How successful the Association has been may be gauged by the falling death rate from tuberculosis,—a cut for which the Association, together with the medical profession and other social and health agencies, has been largely responsible. In 1908, the year the Association was organized, 108 people out of every 100,000 in Wisconsin died of tuberculosis; in 1926 the death rate was 66 per 100,000.

But while victory over the great white plague is unquestionably in sight, efforts against this disease cannot safely be relaxed. This is shown by the increase of tuberculosis deaths during 1926 over those of 1925, an increase occurring entirely among young women under 25 years of age and women in industry. The 1925 death rate from tuberculosis was 62.4.

The importance of continuing the campaign against tuberculosis was well put by Dr. Herman Bundesen, Chicago's health commissioner, at the last annual meeting of the Wisconsin Anti-Tuberculosis Association. He warned against resting on laurels already won, and pointed out that overconfidence spells defeat. The present, he declared, is a crucial moment in the fight against this disease, and to relax efforts now would be nothing short of disastrous.

A CORRECTION

In the October issue of the Journal a record was compiled showing attendance of delegates at the Eau Claire sessions. Through oversight Dr. Stanley J. Seeger, Milwaukee, was credited with attendance at but one session. Dr. Seeger in fact attended both the Tuesday and Wednesday evening sessions.

Federal Legislation of Interest to the Medical Profession Proposed for Seventieth Congress*

Matters of interest to the medical profession that are likely to be considered by the Congress that assembles in Washington on the first Monday in December are scheduled below, with a statement of the policy of the American Medical Association with respect to them. Other matters that may come up for consideration by Congress and the policy of the Association in regard to them will be made known through the pages of the *Journal* or otherwise, as occasion arises. The cooperation of organized medicine and of every physician throughout the country in carrying into effect the policies of the Association with respect to all such measures is necessary, if success is to be attained.

The matters and policies set forth should be brought to the attention of senators and representatives. The American Medical Association, however, asks no pledge nor promise from any senator or representative with respect to his attitude toward any legislation whatsoever. It asks only that he keep an open mind with respect to matters in which medical men are interested until after the profession has had an opportunity of stating its views and its reasons for them.

1. *Safeguards in Promulgation of Regulations Under National Prohibition Act and Harrison Narcotic Act.* Legislation will be proposed to insure notice to all interested parties of every regulation proposed by the Commissioner of Prohibition under the National Prohibition Act and the Harrison Narcotic Act. Such legislation will provide for an opportunity for the medical profession to be heard before the promulgation of any such regulation, for adequate notice of promulgation and reasonable time after promulgation for adjustment of affairs so as to comply with new requirements, and for publication of all such regulations so as to make them readily available to the profession throughout the United States. As the law now stands, the Commissioner of Prohibition can lawfully promulgate a regulation without notice to anyone of his intention to do so, and it may take effect from the moment of its approval by the Secretary of the Treasury. The law now in force does not require that it be published at all. The proposed legislation has the approval of the House of Delegates of the American Medical Association and of various state medical associations.

2. *Sale of Dangerous Cosmetics, Etc.* Legislation will be proposed to safeguard the people against the manufacture, distribution, and commercial use of dangerous cosmetics, etc. Such legislation originated in the Section on Dermatology and Syphilology of the American Medical Association and has received the approval of the House of Delegates. It calls for supervision and control by the federal government of interstate and foreign commerce in cosmetics, etc., and of the manufacture and sale of such articles in the District of Columbia and other places under the exclusive jurisdiction of the federal government.

3. *Federal Income Tax and Reduction of Traveling Expenses.* Legislation will be proposed to give physicians the right to deduct in the computation of their federal income taxes traveling expenses incurred in attending meetings of medical organizations. A similar right is now granted chemists, ministers, corporations, and, it is believed, business men generally. This matter has been called to the attention of the Congressional Joint Committee on the Revision of the Revenue Act. It is hoped that it may be adjusted without having recourse to legislation. Should legislation be required, however, the support of all senators and representatives will favor its enactment.

4. *Amendment of National Prohibition Act.* Legislation will be proposed to permit physicians to prescribe for patients in need of alcohol and alcoholic liquors such amounts as the attending physician believes necessary. The proposed legislation will provide for such reasonable restrictions as the Board of Trustees deems wise and best after a conference with the Commissioner of Prohibition. This proposed legislation has received the endorsement of the House of Delegates of the American Medical Association.

5. *Pay of Medical Officers in the Army and Navy Retired on Account of Disabilities Incurred in Line of Duty in the World War.* Legislation will be proposed, it is believed, to secure for medical officers who served in the temporary forces of the army and navy during the World War and who were disabled by injuries or diseases resulting in the discharge of duty, the same retire-

*From Bulletin, A. M. A., November, 1927.

ment privileges as are accorded to medical officers in the regular army and navy under similar conditions. Such legislation has received the approval of the House of Delegates of the American Medical Association.

6. *Medical, Surgical and Hospital Services for Veterans Suffering from Diseases and Injuries not of Service Origin.* Legislation may be proposed to perpetuate and enlarge the free medical, surgical and hospital services now given to veterans, rich and poor, for injuries and diseases *not* incurred in the line of duty. The World War Veterans Act of 1924 authorized the Director of the Veterans' Bureau to admit to hospitals under his control veterans of all wars, military occupations, and expeditions subsequent to 1897 *without regard to the origin of their disabilities,* so far as the needs of veterans suffering from injuries and disabilities *of service origin* might permit. As a result, during the fiscal year 1925, there was an increase of 20 per cent in admissions to such hospitals, and on an average for every two veterans admitted for service-connected disabilities one veteran was admitted for a non-service-connected disabilities. The announced building program of the Veterans' Bureau, however, plans not to reduce the capacity of its hospitals so as to provide only for veterans suffering from service-connected disabilities; it plans to maintain such hospitals on their present basis, thus perpetuating all beds now available for non-service-connected injuries and disabilities. This will allow, too, for an increase in the number of such beds, as the demand for beds for the treatment of service-connected injuries and disabilities will diminish as time goes on. What the plan proposes is the maintenance and enlargement of the system of federal state medicine already begun under the World War Veterans' Act of 1924. The American Medical Association does not desire the diminution by even a single bed of the facilities necessary for veterans suffering from disabilities of service origin. But legislation that will provide and maintain, and even enlarge, at government expense, the capacity of the hospitals under the control of the Veterans' Bureau so as to provide for the free treatment of patients, rich and poor, suffering from injuries and disabilities in no way whatsoever connected with service, has been condemned by the Board of Trustees of the Association.

7. *Protection of Residents of the District of Columbia from Incompetent Healers.* Legislation will be proposed to drive incompetent, unlicensed practitioners of the healing art from the District of Columbia and to hinder their return. Through lax enforcement of the medical practice act now in force, and possibly to a certain extent because of inadequacies in it, a large number of unlicensed osteopaths, chiropractors and other healers have established themselves in the District of Columbia and are now engaged in the diagnosis of diseases and injuries. The situation is a menace to the health of all who reside permanently or temporarily in the District. The very number of such unlicensed persons makes it difficult to dislodge them, and various organized groups of irregular practitioners see the advantage of recognition by the Congress of the United States and exert their utmost endeavors to obtain it. At the request of the Medical Society of the District of Columbia, the House of Delegates committed the American Medical Association to the support of an effort to obtain the enactment of a practice act for the District that will protect the people against incompetence and quackery. Congress, however, is the only legislature that the District of Columbia has. Every senator and representative throughout the United States is, therefore, a legislator for the District. It is for that reason that appeals should be directed to them for sane legislation for the protection of the people of the District.

8. *Sheppard-Towner Maternity and Infancy Legislation.* It is rumored that legislation will be introduced to authorize the continuance of federal activities under the Sheppard-Towner Maternity and Infancy Act, after the expiration of the period to which such activities are now limited by law. The rumor may have no foundation, however, for it was widely understood when the life of the Sheppard-Towner Maternity and Infancy Act was extended by the Sixty-Ninth Congress that the proponents of such legislation would not ask that the policy embodied in that act be continued beyond the time limit then set, June 30, 1929. If legislation is proposed to extend the life of the act beyond the time limit set or to embody the principles of the act in other legislation it should be borne in mind that the House of Delegates of the American Medical Association has gone on record as firmly opposed to the act and to the policy of the act.

THE JOURNAL BOOK SHELF

Manual of the Diseases of the Eye. For students and general practitioners. By Charles H. May, M. D., Director and Visiting Surgeon, Eye Service, Belleview Hospital, New York, 1916 to 1926; Instructor in Ophthalmology, College of Physicians and Surgeons, Columbia University, New York. Twelfth edition, revised, with 374 original illustrations, including 23 plates, with 73 colored figures. Price, $4.00. William Wood & Company, New York, 1927.

Nineteenth Report of The Henry Phipps Institute, University of Pennsylvania. For the study, treatment and prevention of tuberculosis. Henry Phipps Institute, Seventh and Lombard Sts., Philadelphia, 1927.

A Text Book on Pathology. By Alfred Stengel, M. D., Professor of Medicine, University of Pennsylvania, and Herbert Fox, M. D., Professor of Comparative Pathology, and Director of the Pepper Laboratory of Clinical Medicine, University of Pennsylvania. Eighth edition, reset. Octavo of 1138 pages with 552 text illustrations, many in colors, and 18 colored plates. Cloth, $10.00 net. W. B. Saunders Company, Philadelphia and London, 1927.

Heart and Athletics. Clinical researches upon the influence of athletics upon the heart. By Dr. Felix Deutsch, Privatdocent in Internal Medicine at the University of Vienna, and Dr. Emil Kauf, Assistant at the "Heart Station" in Vienna. English translation by Louis M. Warfield, M. D., former Professor of Internal Medicine, University of Michigan. Price, $2.50. C. V. Mosby Company, St. Louis, 1927.

Textbook on Diseases of the Skin and Syphilis. Designed for the use of students and practitioners. Albert Strickler, M. D., Professor of Dermatology and Syphilology, Temple University, Department of Medicine. Cloth. Price, $8.00, pp. 689, with 218 illustrations. Philadelphia, F. A. Davis Company, 1927.

Surgical Clinics of North America. Vol. VII, No. 3, Chicago number, June, 1927. Pages, 330, with 81 illustrations. Per clinic year, February, 1927, to December, 1927. Paper, $12.00; cloth, $16.00. W. B. Saunders Co., Philadelphia and London.

Potassium and Tartrates. A review of the literature on their physiological effects. By Ralph W. Webster, M. D., Prof. of Medical Jurisprudence in University of Chicago. The Commonwealth Press, Inc., 1112 South Wabash Ave., Chicago.

Text Book of Bacteriology. By William W. Ford, M. D., Professor of Bacteriology, School of Hygiene and Public Health; Lecturer on Hygiene, School of Medicine, Johns Hopkins University. Octavo of 1,069 pages with 186 illustrations. Cloth, $8.50 net. W. B. Saunders Company, Philadelphia and London, 1927.

Medical Clinics of North America. Vol. II. No. 1, Chicago number, July, 1927. Octavo of 294 pages with 26 illustrations. Paper, $12.00; cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

Feeding and the Nutritional Disorders in Infancy and Childhood. By Julius H. Hess, M. D., Professor and Head of the Department of Pediatrics, University of Illinois College of Medicine; Attending Pediatrician to Cook County, Michael Reese and Englewood Hospitals, Chicago. Illustrated with forty-five engravings in the text and one full-page colored plate. Fifth revised and enlarged edition. Price $4.50 net. F. A. Davis Company, Philadelphia, 1927.

BOOKS RECEIVED FOR REVIEW

American Medicine and the People's Health. By Harry H. Moore, Public Health Economist, United States Public Health Service; Author of "Public Health in the United States." A survey of the organization of medicine in the United States with special reference to the adjustment of medical service to social and economic change. Price, $5.00. D. Appleton & Company, New York and London.

The Rockefeller Foundation. Annual Report, 1926. Published by Rockefeller Foundation, 61 Broadway, New York.

Ophthalmoscopy, Retinoscopy and Refraction. By W. A. Fisher, M. D., Prof. of Ophthalmology, Chicago Eye, Ear, Nose and Throat College; formerly Prof. of Clinical Ophthalmology, University of Illinois. Second revised and enlarged edition; with 260 illustrations, including 48 colored plates. Price, $3.75. F. A. Davis Company, Philadelphia.

Ophthalmic Optics. By Alfred Cowan, M. D., Assistant Prof. of Ophthalmology, Graduate School of Medicine, University of Pennsylvania. Illustrated. Price, $3.50. F. A. Davis Company, Philadelphia.

Principles of Sanitation. A practical handbook for public health workers. By C. H. Kibbey. Illustrated. Price, $3.50. F. A. Davis Company, Philadelphia.

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Secretary, Mr. J. G. Crownhart, 153 E. Wells Street, Milwaukee, Wisconsin. These new books will be loaned for an inspection period only.

American Medicine and the People's Health. By Harry H. Moore, Public Health Economist, United States Public Health Service; Author of "Public Health in the United States." A survey of the organization of medicine in the United States with special reference to the adjustment of medical service to social and economic change. Price, $5.00. D. Appleton & Company, New York and London.

If there is any one topic of unfailing interest to the individual practitioner it is the trend of medical times. Mr. Moore has compiled in able form extensive information on present conditions and suggested projects in the field of medical practice. Throughout the volume Mr. Moore has quoted liberally of the criticisms and suggestions made by prominent physicians throughout the United States.

The volume is designed to present the economic, sociological and political aspect of the chief facts available upon which are based an understanding of the trend of the times. We are confident that this book will prove as interesting as a novel to any physician and give him a better understanding of conditions as they are.—J. G. C.

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Physical Diagnosis. By Richard C. Cabot, M. D., Professor of Medicine in Harvard University. Ninth Edition. Revised and enlarged with six plates and 279 figures in the text. William Wood & Co., New York, 1927.

This very popular book on physical diagnosis is now in its ninth edition. Important changes have been made in the chapter on cardio-vascular diseases. Since the first edition in 1905 there has been considerable advance in physical diagnosis. Here and there it would seem as though changes might have been made in order to bring the subject up to date. Such a book as this is only an outline. Often the descriptions are very sketchy. Still what can one expect? Physical diagnosis can not be learned from books. It is a life-long study upon patients. As a guide this book fulfills its purpose.—L. M. W.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared original articles by leading members of the medical profession throughout the world. Vol. III, thirty-seventh series. J. B. Lippincott Company, Philadelphia and London, 1927.

This volume of this well-known series is divided into ten articles on Diagnosis and Treatment, one on Medicine, one on Surgery, one on Obstetrics, one on Neurology, one on Medical History, and two on Post-Graduate Study. Among these various subjects several articles stand out. One is on "Colitis: Catarrhal, Mucous, Ulcerative," by T. R. Brown, another one "The Clinical Aspects of Thrombo-Angiitis Obliterans," by W. A. Steel and another is on "Pneumococcus Meningitis and Endocarditis," by H. I. and H. Z. Goldstein. The last article reviews all the literature and has a bibliography. This impresses the reviewer as an unusually good number. This series, now the thirty-seventh, have been deservedly popular with the profession. Certainly this present volume is well worth having on one's bookshelf.—L. M. W.

Clinical Case Taking. Supplement to Methods in Medicine. By George R. Herrmann, M. D., Assistant Professor of Medicine, Tulane University, New Orleans. Price, $1.50. C. V. Mosby Co., St. Louis, 1927.

To teach the medical student how to take a good history is a large part of his education. Many hospitals have more or less complete outlines which the students and internes follow. A comprehensive, yet not too voluminous, set of suggestions should be welcomed by all instructors.

To all such who are struggling with students this little book of Herrmann's can be highly recommended. It fulfills all the requirements. It is brief, readable, crowded with valuable points, and reasonable. It should have a large sale among senior students and hospital internes.—L. M. W.

Getting Well and Staying Well. A book for tuberculous patients, public health nurses, and doctors. By John Potts, M. D., Fort Worth, Texas. Price, $2.00. C. V. Mosby Co., St. Louis, 1927.

A number of such popular books are now available, so that the reviewer picked up this with a sigh. To his surprise he found himself reading it with interest. It is a splendid book to put into the hands of lay people. It appeals to the reviewer perhaps because the author says well many things which the reviewer has said but has said crudely. Above all, the author's whole attitude is sane. He has no special formula to exploit. Would that more books left one after reading them with the feeling, "Now that man not only has both feet firmly on the ground but he apparently knows his subject."

There is some repetition of subjects in several chapters, the words being almost identical. However, this may not be a fault. Reiteration drives home facts and the author's object is to drive the facts home. To tuberculosis patients, public health nurses and many doctors this book is recommended.—L. M. W.

Gonococcal Infection in the Male. By Abr. L. Wolbarst, M. D., Urologist and Director of Urologic Clinics, Beth Israel Hospital, New York. With eighty-nine illustrations, including seven color plates. Price, $5.50. C. V. Mosby Co., St. Louis, 1927.

Since the discovery of the gonococcus by Neisser in 1879, rapid advances have been made in the diagnosis and treatment of gonorrhea, these advances are to be found widely scattered through the medical literature of the world.

It is generally agreed that 60 per cent of all adult males have suffered from gonorrhea at one time or another, so that a monogram which gives the general practitioner and undergraduate medical student the essentials for an early diagnosis and a complete description of various treatments which have proven satisfactory in large clinics will serve a useful purpose. This, Wolbarst has accomplished in his manual—"Gonococcal Infection in the Male."

The World War served at least one useful purpose when it brought a knowledge of sex and personal prophylaxis against venereal disease within the purview of the average man and woman. With the introduction of personal prophylaxis and with a growing tolerance toward sex education, it is hoped that the incident of gonorrhea will be greatly reduced.

The reviewer suggests that a bibliography accompany each chapter in the next edition.—W. J. C.

Fistula of the Anus and Rectum. By Charles John Drueck, M. D., Professor of Rectal Diseases, Post Graduate Hospital and Medical School, Chicago. With sixty-six original illustrations. Price net. F. A. Davis Company. Philadelphia, 1927.

The reading of this monograph has been a distinct pleasure to the reviewer and should be to anyone interested in a scientific presentation of this subject. The author has a clear, concise form in his writing which brings before the reader a vision of conditions as they actually exist, as well as the word story.

Rectal pathology is still a "bugbear" to the medical profession in general and will continue as such until a better understanding is obtained. Basically such an understanding must be taught in our medical schools, and a large number realizing this fact have already established courses in proctology. It is hoped that this monograph may have a wide distribution as it is our belief that it is a valuable book and will prove very useful to the practicing physician.—C. W. M.

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SWIMMING POOL SANITATION

(Continued from Page 33.)

practically bacteria free. If, however, the filter is shut off during the night, without sufficient free chlorine present, and the warm pool water allowed to remain in the filter, the bacterial count in the morning was found to be much higher than it had been the day before. If the filtration system is to be shut off during the night, the filter should be washed and chlorinated in order to prevent growth of bacteria in it. If, however, sufficient free chlorine, .15 ppm., is present this procedure is not necessary.

Studies were made of the amount of chlorine necessary to keep a pool sterile and also to determine the amount of chlorine which may be tolerated without discomfort by the bathers. The amount of chlorine necessary to maintain a sterile pool depends upon the organic content of the water. In any event a small amount of free chlorine should be present. This may be tested for colorimetrically with ortho-tolnidine. For the Madison water, 0.15 parts per million of free chlorine are satisfactory. This amount of free chlorine will maintain the pool in a condition free from bacteria and will not in any way cause an unpleasant odor in the room, nor will it cause any irritation to the bathers. It seems possible that the chlorine combines with the organic material in the water to form chloramines and that these substances have a prolonged germicidal action.

The possibility of infection resulting from bathing in swimming pools may be reduced to a minimum by proper control of the bacterial count of the water through the use of chlorine and filtration, and also by control of the temperature of the water and the air in the room. The most satisfactory temperature for the water is 72° F. with the air in the room about 2 degrees warmer. The air in the room should not be more than 8 degrees warmer nor 2 degrees colder than the water in the pool. The number of bathers using the pool at any one time is another important point. In general, there should never be more than twenty people per 1,000 gallons of freshly filtered water. The load on the pool will then depend to a certain extent upon the capacity of the filtration plant.

SUMMARY

Swimming pools may be maintained in a satisfactory sanitary condition by filtration and chlorination. A small residuum of free chlorine should be maintained in the pool at a point depending upon the organic content of the water and not to exceed a point where irritation of mucous membranes is possible. Ortho-toluidine may be employed to test for the presence of free chlorine. The water in the pool should be such that the bottom of the pool is visible at all times. The water should be maintained at a temperature of 72° F. with the air in the room about two degrees warmer. The bath load should not be greater than twenty people per 1,000 gallons of clean water.

THE MEDICAL REFEREE

(Continued from Page 51.)

go that additional step. There is no large organization, no large group of individuals, who are opposed to it. It seems to me that it ought to have the enthusiastic support of the medical profession. I daresay that you men who have been in court in criminal cases, and those who have been in court in jury trials generally, have come away more often than not with a sense of disgust at the manner in which the trial was conducted—unscientific to the last degree. The idea of a medical referee as we know it now is in the highest degree scientific, it seems to me. If that idea could be extended to every form of personal injury case we will have made a great stride in the right direction, and that is the idea that I am so anxious to put to you to-night as doctors and also as citizens of the community.

The proposition will not come up at the present session of the legislature, but probably will come up in the 1929 session. There will be a bill before

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that legislature advocating this plan that I am discussing with you here to-night. The Federation of Labor has a legislative committee appointed to work at this proposal, and it will undoubtedly have the support of labor. It will have the support of the Bar, with the exception of those individuals who make their living out of the plaintiff's side of personal injury litigation; undoubtedly they will enthusiastically oppose it. But there is no large group of capital or labor, or any single profession, or any single organization, that will be opposed to a proposition of this kind. And it will be the greatest single forward step to extend the idea of the medical referee. (Applause.)

DISCUSSION

CHAIRMAN: The discussion will be continued by Mr. George Crownhart.

MR. J. G. CROWNHART: Mr. President and Members of the Academy: I was intensely interested in Mr. Doe's presentation to-night. I offer no compliments to Mr. Doe beyond stating the fact that knowing the subject, and knowing Mr. Doe, the Editorial Board has here to-night a reporter, so that all the two thousand members of the State Society may have the opportunity of reading his address in the Wisconsin Medical Journal.

Mr. Doe emphasized the point of the panel versus the free choice, and spoke in favor of the panel system. I want to bring up one other angle of that. In Ohio there is a fixed fee schedule in the law. Now you understand if they have the panel system the employer or the insurance company has the right to say what the charges shall be. While they may never fix any scale, obviously if a physician is consistently overcharging a company or employer, his name will no longer appear on the panel when the next panel is chosen. That is, I believe, far preferable to having a fixed fee scale in the law. They recently secured in Ohio a few minor amendments to the fee scale, and the secretary of the Ohio State Medical Society declared that those few minor amendments that they have been trying to get the legislature to adopt in more than one session, meant a difference in the income of the profession in Ohio, of over a million dollars. I bring this before you merely to emphasize the point that if you have free choice there goes with it, as a protection to the Insurance Company and a protection to the employer, a fixed fee scale in the law. Mr. Doe will tell you how hard it is to keep the law abreast with current legal opinion and current medical opinion, and I am sure a fixed fee scale in Wisconsin would operate to the detriment of the public and profession.

I was very much interested in what Mr. Doe had to say with respect to increasing the scope of the Workman's Compensation Act so as to include all personal injury cases. There are two phases that were particularly interesting to me. One was the fact that the Compensation Board as it now exists in Wisconsin, while originally designed with the main object and idea of settling cases quickly so that the injured man or his family would secure the money within a reasonable time, has also brought about a great reduction in the number of accidents and in the loss of time. This is largely because of the fact that as these cases come before one Board constantly, they see repetitions here, there and every place, and soon come to notice the fact that these accidents are due to the lack of some simple little safeguard. They bring these matters to the attention of the employers throughout the state, and thus reduce the number of accidents.

When I was a legislative reporter in Madison in 1922 it was found that over one-half of the cases on the calendar of the Supreme Court of the State of Wisconsin were automobile cases. Now I am sure that they have very, very few appeals from the awards of the Industrial Commission. I believe, as Mr. Doe has pointed out, that the amount of litigation, and the time consumed in waiting for a verdict, and the final verdict in the Supreme Court, and the number of appeals to the Supreme Court, would be greatly reduced. And even though some injured man might not think he was receiving the entire award to which he was entitled, the amount that was awarded would be promptly received.

Mr. Doe, I have been very much interested in your presentation of this subject. (Applause.)

DR. GILBERT SEAMAN: I was very much interested and very much enlightened by what Mr. Doe had to say. It certainly was a fine presentation of a very interesting subject. There are a great many angles that might be susceptible of discussion in the matter of the appointment and the general use of medical referees, in order to allay the nuisance of the expert witness. To my mind the medical profession has suffered greatly in public estimation by the shortsightedness of courts and judicial systems in respect to expert testimony. Not all of the fault lies at the door of the medical profession. I think that would be readily admitted by most lawyers.

I was interested in an announcement recently made that either the State Medical Society of Oklahoma or the Local Medical Society in Oklahoma City had passed a resolution which has for its purpose the putting into effect of a rule that men will not accept service as medical witnesses unless on appointment by the court as experts or as referees. That they will not accept the partisan position which is too often forced upon a medical man when he takes a fee or an engagement to represent one side of the case. I think that is interesting, and possibly in the course of time it may become the generally accepted view of the medical profession. I noticed in a recent number of the Journal of the American Medical Association that it was commented upon approvingly.

Now on the matter of the wide difference of opinion as between medical men on the question of the degree of disability or the extent of injury in a given case, you will never get away from that. There are certain situations where legitimately there may be a rather

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pronounced difference of opinion, based upon the consideration which each individual has given to the particular case. I remember one case where the consideration was the degree of injury. The man had a nerve deafness. He was a leader of an orchestra, had been trained as a musician from early boyhood, and was making a very good living, in fact a large income, from his position as leader of an orchestra. He did have a certain degree of nerve deafness which destroyed his usefulness as a leader of an orchestra. He was considered to be fifteen per cent disabled. As a matter of fact, so far as his occupation was concerned, he was almost wholly disabled, because of the loss of the perception of tone. I cite this as an instance of where one man, without due consideration, said, "yes, he has a certain degree of deafness but it is not very disabling, he is fifteen per cent disabled." Another man said that he was seventy-five per cent disabled. The second man had given the matter real consideration. It was finally determined that the man was sixty-five per cent disabled, and I think very fairly and justly so determined.

I heard a very interesting discussion, Mr. Doe, some years ago which on one side was led by General Winkler, in which General Winkler contended that there never could be a system under our law and constitution which would take away from a man the right to introduce such testimony as he chose to introduce, or as he saw fit to introduce, or as he might reasonably claim was proper testimony. In other words, that the law was such that it would be impossible to put into effect a system by which the courts would designate the expert or the medical witness if you please, and deny the litigant the right to introduce others. I, of course, have no opinion on the subject, but it was an interesting discussion and it was a long time ago. I have forgotten the main contestant on the other side of the question, but I was very much interested in General Winkler's opinion on the subject at the time. I do not know whether that is the law or whether there is a general opinion.

A question occurs to me. The suggestion is made to extend the Workmen's Compensation Act to automobile accidents. That is an extension of course. It has not the argument altogether that applied to the questions involved in the first consideration of the Workmen's Compensation Act. The question arises, if you extend it to that kind of accidents and other accidents why would it not be logical to extend it to disease. A man dead of disease is just as dead as though he were killed by accident, and his family is in the same position that they would be if he were killed by accident. It seems to me that that extension would indicate probabilities of still further extension.

Dr. G. J. Kaumheimer: Mr. Chairman and Gentlemen. While Mr. Doe was speaking I thought of a similar address made by Mr. Zabel at the annual meeting of the County Society in 1918. He at that time stated that it is often the fault of the lawyer that the doctors disagree, and spoke of a case that occurred in England, where the question of the value of a piece of property was concerned. One lawyer consulted some forty different people until he found one whose idea of the value of that property agreed with the value that his client put upon it. We find the same situation here. The honest physician tries to give an honest opinion. The bird with soiled feathers, whether he is a doctor of law or a doctor of medicine flocks to his mates. The ambulance chaser knows his doctor and knows that he would testify to most anything he wants him to. It has happened to me that people have come with great complaints, and I could not find anything, and said so. I know that they went before the court, but I was not called. Some other man more sympathetic was called. I think you have all had more or less experience in that way. I do not know how it can be prevented. Ethics exist only for the respectable portion of any profession. The ambulance chaser and his medical assistant will always exist. I do not know how you can get rid of them, unless perhaps through the medical referee. The insurance companies are somewhat to blame. They are looking for men that are not too enthusiastic about it. I know when the law was first passed and the average fee bill was fixed, certain small insurance companies sent around the inquiry, "if we appoint you how much discount will you give us from that fee bill," and have even proposed that the doctor should pay for the x-rays taken in fracture cases out of his reduced fees. They may say that they like the Compensation Act, but there are lots of them that are not in business for anything but the mazuma.

It is not always the fault of the doctor if he claims that a patient is badly injured, because some of these people make very extravagant claims. Another point that Mr. Doe made: I know it is sometimes very hard to cure some of those fellows, especially if they carry a little insurance on the side. Just as soon as you cure them of a sore arm they will develop a headache. They are getting $10 or $12 a week from a lodge or some insurance company. Just as soon as you cure their headache they have a bad cough, which is mainly due to the fact that they fell downstairs six weeks before. It happened to me this summer that a neighboring physician who was treating a man for a little abrasion on the finger wanted to go on his vacation. He dressed the finger and told him to come in again "in two days." When he came he did not have the same dressing on, and said, "Oh, that finger hurt me so much that I took the dressing off." The doctor did go on his vacation and asked me to look after this man, and we gave him strict orders not to take off any dressings and if it pained him, to report. But we fixed the dressing in such a way that we could tell whether he took it off or not. At the end of the week there wasn't any injury to be seen. Well, the man said, "that is a nice way, I get hurt and get well in a week, I don't get any compensation. Can't you report me as sick for another week?" That is the attitude that some people take. The doctor that tries to be honest about it very often runs against the severe opposition of his patient.

Chairman: Is there further discussion?

Dr. C. M. Echols: I should like to ask Mr. Doe

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what in his opinion would be the chief sources of opposition to the proposed bill which he says will be introduced sooner or later, and also how influential and numerous would be the members of the legal profession who would oppose such a bill.

Dr. Seaman's reference to rights under the constitution reminds me that in my school days I read in the constitution that the "right of trial by jury shall not be abridged." Would that apply to plaintiffs who might insist upon their right of trial by jury in case of personal injury?

MR. ARTHUR B. DOE: The point that you mentioned last about trial by jury was the greatest obstacle originally to the passage of the Compensation Law. There is no more reason why a man who is injured in a factory should not have a trial by jury than why a man who is injured in an automobile should not. The way that problem was met was this: The Compensation Act is elective. The St. Paul Railroad is not under the law. The reason they are not under the law is that they have elected not to be under the law. That is the feature that complies with the constitution. Anyone who wants a trial by jury can have it by electing not to become subject to the Act. The way it works out is this: Election is practically compulsory, for the reason that all defenses are taken away if you do not come under the law. The first three sections of the Compensation Act abolish all defenses to people who are not subject to it. In other words, if an employee of the St. Paul Road is injured the railroad cannot set up the defense of assumption of risk, fellow servant, or contributory negligence. The result is that employers find it in the highest degree hazardous not to come under the law, as their liability is so much larger if they are not under the law than if they are under it. Now similarly in automobile cases, an elective system can be worked out. We think it can. The difficulty, of course, does not begin with the driver of the automobile; it begins with the claimant. The way that was handled under the Compensation Act was that the employees came under the Act by operation of the statute, unless they filed an affirmative election not to come under the Act. All who had not so filed by a certain date automatically came under the Act. They could then get out by filing an election to get out, and then after the lapse of a certain time they are out. There is no reason why that cannot be worked out in the case of automobile accidents. The taking out of a license by any man to drive an automobile constitutes an election to come under the law, unless he files an election not to come under the law, in which case he shall not have any defenses. What is the answer? He will come under the law. The same thing as to people who are injured. Any man who elected not to come under the law as an individual could do so, but he would be automatically subject if he did not file an election not to come under the law. That is the way the constitutional difficulty was met in the Compensation Act. I can see no practical reason why it cannot be met in the same way on this proposal. Does that answer your question, Doctor?

DR. ECHOLS: Yes, it answers that part of it. I also asked about the opposition.

MR. DOE: I believe there will be strenuous opposition on two scores. The first will come from the lawyers who make their living out of the personal injury business. They are not very numerous. They are not a substantial part of the total membership of the Bar. They are powerful politically, but there are not enough of them so that unaided they could get very far in opposing it. They opposed the Compensation Act just as vehemently as they could, unsuccessfully. They were in the same position as they are now. They made their living then out of the master and servant cases, before the automobile came in. The abolition of the master and servant cases by the passage of the Compensation Act simply drove them out of business, except insofar as the automobile has kept them alive since. So I cannot see that that group will be any larger or more powerful than it was in the day when the Compensation Act was passed.

The chief obstacle is going to come from the farmers and from people of small means on the score of expense, because to pass a law of this kind without having unlimited insurance would be perfectly futile. The main object of the law would not be accomplished. If you simply substitute for the man who now has no insurance a remedy before a Commission instead of a jury, you have not accomplished much. The insurance provision of the Compensation Act is that everybody must have an unlimited liability policy, unless he can furnish to the state a satisfactory financial statement showing his responsibility. Now an unlimited automobile liability policy would be an expensive thing, but I believe that it can be worked out to a point where, on the average car, that is, the light sixes and under, an unlimited liability policy can be bought for under $40 a year. And our idea is that a man will be unable to get a license until he produces proof that he has such a policy. Then by requiring the licenses for the new year to be on the car before the first of January there cannot be any lapsing of insurance. The people who are not paying that $40 a year will be bitterly opposed to this law. But it is our position that a man who cannot afford that additional expense had better be kept off the street than to subject the body politic to the consequences. So if we can work out an unlimited liability policy that a man can buy for $40 a year, and that simply becomes an added price on his license, in effect, we think the plan can be worked out. There was opposition on the part of employers when the Compensation Act was passed, because compensation insurance originally was very expensive. But it was compulsory and there was no escape if you could not furnish a financial statement. So the parallel is rather close right along the line. I think if you inquired around among people on the street of modest means whether they do not think a man ought not to be allowed to drive a car on the street without insurance, most of them would agree with you, particularly city dwellers. And if the expense can be kept down to a figure that is reasonable, I do not believe

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that obstacle is going to defeat the enactment of such a law. Those two propositions are the only things that we have encountered so far that are going to cause serious trouble—expense, and those who make a living out of the business. Incidentally, I make my living out of the business, and would be one of the sufferers from such legislation, but that does not stop me from being interested in it.

DR. GILBERT E. SEAMAN: Mr. President, I wonder if Mr. Doe would refer to that matter of the legal or constitutional objection to courts or judicial bodies naming the expert witnesses, and excluding others. Do you get the point?

MR. DOE: I think it is impossible. I think what General Winkler said long before the Compensation Act was passed no doubt—

DR. SEAMAN: Yes.

MR. DOE: —is still true, that a law which made it impossible for a litigant to offer testimony could not stand. But practically that does not constitute an obstacle. The Compensation Act has been attacked on constitutional grounds a good many times, and from a good many angles. When the Industrial Commission appoints a medical referee now, and for all practical purposes decides the case on what he says, there never is a situation where there is not sufficient evidence to uphold that decision from other witnesses, in case it should be attacked upon that ground. But I believe that we could not pass a law that would make it impossible for the plaintiff to offer testimony of such witnesses as he might care to produce.

DR. SEAMAN: Of course it becomes of greater importance where. for instance, the question of insanity is involved, or something of that character.

MR. DOE: I am not a criminal lawyer and have never tried a criminal case where any medical issue was involved, and I really would not want to express an opinion on a criminal trial. But on a civil trial you could never do anything with a compulsory medical referee law as long as you have a jury, because the jury would not be bound by the testimony of a medical referee at all, and it would not remedy the evil that we are after unless the decision of the medical referee was binding. I agree with General Winkler that you could not do it. You could not have a case where you could exclude such evidence as the plaintiff cared to offer.

DR. SEAMAN: What about the matter of the extension of this protection to disease?

MR. DOE: When you made that suggestion before, this thought came to me: The Compensation Act now extends to occupational diseases—to injuries, as it says in the law. The word "occupational disease" only appears in the law by indirection. It says that a man is entitled to compensation for the injury, and that occupational diseases shall be considered an injury for the purposes of the law. Now you cannot have an occupational disease from an automobile accident. A man who is hit by an automobile may be a dormant T. B., and after the accident may be an active T. B.; but if he is, it is not an occupational disease, it is a result of the accident. As long as you are consistent and say that a man who is injured in an automobile accident shall be compensated for such damages as flow from the accident, any disease of course, that flows from the accident will be included, just as it is now in the common law. For instance, a case was tried in Waukesha last week where a man was injured in an automobile collision, and claimed that previous to the injury he had never had any heart trouble, and that after the accident he had a decompensated heart. That testimony was allowed to go in, and two doctors in Waukesha testified that in their opinion his heart condition was due to this automobile collision, which I take it is a matter of disease following an injury. The reason we cannot go on indefinitely from there and say that because a man has a disease he ought to be paid, is that that is not the theory we are working under. What we are trying to get away from here is fault as a standard of liability. If a man contracts typhoid fever and dies from it, that has nothing to do with the question of fault. This idea is predicated on the proposition that fault as a standard is a wrong and unscientific standard of compensating for these economic losses. And of course disease which is contracted otherwise than as a result of an injury, is not associated with the problem. Do I make myself clear, Doctor?

DR. G. J. KAUMHEIMER: I beg pardon, but if my memory does not fail me I think one of the earliest cases decided by the Supreme Court was a case where typhoid fever was contracted from infected water furnished by an employer.

MR. DOE: Yes, they did. That is the Dells Lumber Company case. They there traced the typhoid germs to the drinking water furnished the employees at the plant. They decided the same way in the case of the Hoberg Paper Company of Green Bay, where 23 employees of one mill contracted typhoid fever. There was typhoid fever in the city of Green Bay, but they thought if 23 employees at one mill had it, there must be something wrong at the mill, and that typhoid fever was the direct result of the employment. Now similarly if there could conceivably be a case where a man could contract typhoid fever as the result of an automobile accident, he ought to be paid, but not otherwise. In other words, there must be that connection in order to have it come under the law.

CHAIRMAN: On behalf of the Society I wish to thank Mr. Doe for being with us to-night. (Applause.)

FATTY ATROPHY FROM INJECTIONS OF INSULIN

Clifford J. Barborka, Rochester, Minn. (Journal A. M. A., Nov. 13, 1926), reports two cases of unusual localized subcutaneous fatty atrophy at the sites of insulin injections. Barborka emphasizes that the desirable site for injecting insulin is where the skin is loose, and that succeeding injections should not be made at the same site. A fold of the skin should be picked up between the thumb and forefinger, and, with the syringe held parallel to the skin the needle should be injected into the fold nearly up to the hilt. The tip of the needle should then feel loose in the soft tissue between the skin and the muscle. The insulin should be gradually forced from the syringe while the needle is withdrawn slowly, so that the injected fluid may be distributed as much as possible; the area should then be massaged in order still further to distribute it.

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EARL STREET AT INDIAN MOUNDS

Jastrow, Prof. of Psychology in the University of Wisconsin. D. Appleton and Company, New York and London, 1926.

This book is a compilation of many more or less related articles on different aspects of abnormal psychology. Some of these selections are excellent, others of less value. Necessarily a book of this character is more or less disconnected and makes difficult reading. It seems to the reviewer that books on abnormal psychology would be a great deal clearer, and that a comprehensive vision of modern psycho-pathology could be more adequately gained through a well connected presentation of modern viewpoints rather than by such a compilation as is here presented. These compilations of selections from different authors do not make for clear conceptions.—B. B. R.

Physiology and Biochemistry in Modern Medicine. By J. J. R. Macleod, M.B., Prof. of Physiology in the University of Toronto, Toronto, Canada; assisted by Roy G. Pearce, A. C. Redfield, N. B. Taylor and J. M. D. Olmsted. Fifth edition, with 291 illustrations, including 9 plates in colors. Price $11.00. C. V. Mosby Company, St. Louis, 1926.

Although there are a number of excellent textbooks available on both physiology and biochemistry, this volume notably is one in which particular emphasis is laid upon the correlation of these subjects and the routine practice of medicine. It may well serve as a guide in applying the facts learned in the laboratory to the bedside study of disease.

The present or fifth edition has been thoroughly revised, and many chapters, such as those dealing with blood, respiration, metabolism, and ductless glands, rewritten. It is an extensive, exhaustive, easily readable, and fascinating volume, suitable alike for the medical student and the graduate physician.—M. R.

The Practice of Medicine. By A. A. Stevens, M.D., Prof. of Applied Therapeutics in the University of Pennsylvania. Second edition, entirely reset. Octavo of 1174 pages. Cloth, $7.50 net. W. B. Saunders Company, Philadelphia and London.

This book meets two very distinct demands:

1. As a text book for the medical student who is having his first experience in the clinic or hospital wards, and needs accurate but of necessity concise description of the conditions he is to encounter and study, this book will act as a very satisfactory guide. Dr. Stevens' many years of experience as a teacher have given him ample opportunity to know the needs of the student and this knowledge is well reflected in the book. Clear and accurate and with sufficient attention to detail to meet the demands of the student, yet not overloaded with probabilities and theories, tending to confuse.

2. As a ready reference for the busy grilled practitioner a book must bring to the reader a résumé of the very latest and best in recent medical literature. In the second edition Dr. Stevens has apparently been very successful in meeting this demand. A fairly careful review of the book gives also the impression not much of value has been missed.—O. L.

DIATHERMY

(Continued from Page 87.)

may be easily cleared up. The indications for diathermy are by no means the same as those for the external application of heat. Diathermy is contraindicated in internal congestion because its general effect is to produce an internal aseptic fever.

In conclusion, it is desired again to emphasize the proposition that the effects of physical agencies upon living tissue deserve careful study in medical circles. It is important that the limitations and dangers of the various forms of physical agencies employed in the treatment of disease be thoroughly understood. It is also important that no one assume to employ these agencies who does not thoroughly know these dangers and limitations. The employment of ultraviolet light and diathermy has become increasingly significant within the last few years. Careful experimental work is necessary to elucidate all the factors involved in their clinical employment.

DISCUSSION.

This interesting paper by Dr. Nagelschmidt was followed by the exhibition of a large number of lantern slides illustrating the use and effects of various types of physical agents in therapeutics. In discussing the paper, Dr. J. C. Elsom pointed out that many of the present forms of physiotherapy are only old methods anciently employed in medicine now appearing in new dress. Professor Terry of the Physics Department pointed out the difficulties of manufacturers of diathermic equipment. In measuring the voltage between electrodes of a diathermy machine, it was found that the voltage was above 8,000, which was very astonishing in view of the fact that a much smaller voltage could electrocute a man if applied in a different way. A diathermic machine is really quiescent for 95 per cent of the time and is active in working up this high voltage only about 5 per cent of the time. The really effective voltage of a diathermic machine is low, in the neighborhood of 30 volts, but it rises rapidly to a peak voltage and then falls off very quickly. The amperage also is high only for an exceedingly short period of time. These facts indicate why it is that living tissue can successfully withstand these currents. Arguing by analogy to radio transmission, the use of a continuous current from vacuum tubes is suggested. This type of current is more easily controlled and does not produce the noise and confusion of the ordinary spark gap machine which may greatly disturb the nervous individual. Dr. J. A. E. Eyster and Dr. Hans Reese also participated in the discussion.

When it appears necessary for the health officer of a town to examine the children in a school district to determine the possible presence of cases of scarlet fever (or other disease), any expense incurred must be paid by the town upon the order of the local board of health, and not by the school district. In the case of a joint district, including the territory in two or more towns, the expense incurred must be paid by the town in which the schoolhouse is located.

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STATE BLUE SKY LAW

(Continued from Page 123.)

problem which the Commission has had to meet. The rabbit sausage story—"fifty-fifty, one horse, one rabbit"—typifies the financial set-up which has been most popular with the professional promoter. It is hardly necessary to argue the unfairness of the set-up which gives the promoters practically all of the profits if the enterprise is successful, and in which they lose practically nothing if the enterprise fails.

The issuance of a straight preferred stock in a new enterprise is held to be unfair and inequitable unless it is accompanied by a sufficient amount of common stock to give the investor a reasonable possible return. "The greater the return the greater the risk" is a common warning in the investment field. Conversely, it ought to be a cardinal principle in finance that the greater the risk, the greater should be the return to which the investor is entitled. The intelligent and experienced investor may be willing to take a chance now and then if the possible return is commensurate with the risk involved, but it is only the inexperienced or ignorant investor who can be induced to invest money in a new, untried, and highly speculative enterprise with no prospects of getting dividends greater than the interest return on a reasonably good bond. Without attempting to fix any hard and fast rule with respect to the financial set-up of a new enterprise, the Commission requires that the distribution of profits be fair and equitable.

The investor should remember that it was not the intent of the legislature, in enacting the Securities Law, to prevent speculation, or to stop the flow of capital into new enterprises merely because many of them eventually fail. The whole purposes of blue sky legislation is admirably summed up in the decision of a New York Court rendered in October, 1924:

"The statute is aimed at fraudulent devices and false representations. It was not designed to prevent speculation or investment. * * *

"If one shares the confidence and optimism of the inventor in a device, he should not be prevented from purchasing a share in it. The legislature sought only to protect against misleading and fraudulent devices and statements.

"If the facts are clear and the purchaser of stock is not misled, he is free to do as he pleases. The law seeks to guard the investor from fraud, not from his own decisions deliberately and freely made."

It would be absurd to assert that the Securities Act is letter perfect. I think, without doubt, it is as effective in accomplishing its purpose as any similar act in the country. There have been losses since its enactment, to be sure, and there always will be losses in spite of the most careful administration of the act. But most of such losses, analysis will show, arise, not out of fraud, but out of the mistakes or misfortunes of corporate management, over which the broad control of the Securities Act does not extend. Only when an intelligent public learns the art of wise selection of investments will the need for blue sky legislation cease to exist.

THERAPEUTIC NOTES

NEW AND NONOFFICIAL REMEDIES

In addition to the articles enumerated previously, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Cutter Laboratory:
- Diphtheria Toxin-Antitoxin Mixture 0.1 L+.

Eli Lilly & Co.:
- Cholera Vaccine, Prophylactic.
- Plague Vaccine, Prophylactic.
- Old Tuberculin Human Strain Concentrated.
- Pirquet Test.
- Tuberculin Ointment for the Moro Percutaneous Test.
- Tuberculin T. R. Concentrated Human Strain.
- Tuberculin B. E. Concentrated Human Strain.
- Tuberculin B. F. Concentrated Human Strain.
- Ampoules Glucose (Dextrose U. S. P.) Lilly 10 gm., 20 c.c.
- Ampoules Glucose (Dextrose U. S. P.) Lilly 25 gm., 50 c.c.

H. A. Metz Laboratories, Inc.:
- Gynergen—
  - Ampules Gynergen, 1.1 c.c.
  - Tablets Gynergen, 0.001 gm.

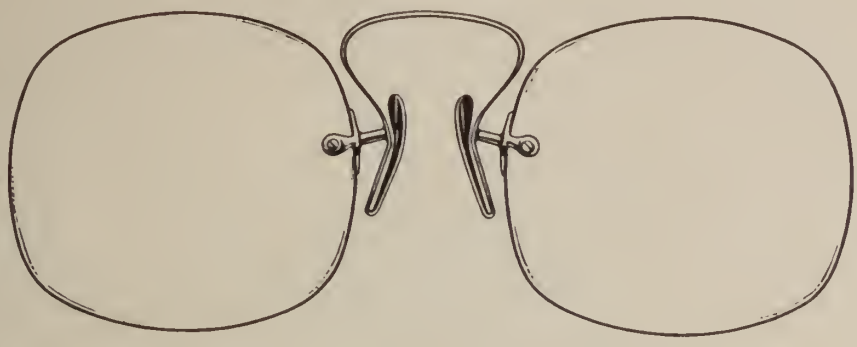
Parke, Davis & Co.:
- Bismuth Salicylate in Oil—P. D. & Co.

Winthrop Chemical Co.:
- Tutocain—
  - Tablets Tutocain No. 1 (with epinephrin) 0.03 gm.
  - Tablets Tutocain No. 2 (with epinephrin) 0.03 gm.
  - Tablets Tutocain No. 3, 0.03 gm.
  - Tablets Tutocain No. 4 (with epinephrin) 0.05 gm.
  - Tablets Tutocain No. 5, 0.1 gm.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

Tetanus Antitoxin for Human Use (New and Non official Remedies, 1926, p. 333). This product is also marketed in packages of one syringe containing 10,000



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units and in packages of one syringe containing 20,000 units. Cutter Laboratory, Berkeley, Calif. (Jour. A. M. A., Dec. 4, 1926, p. 1917.)

Typhoid Prophylactic (New and Nonofficial Remedies, 1926, p. 359). This typhoid vaccine is also marketed in packages of one syringe and in a 20 c.c. bottle. Cutter Laboratory, Berkeley, Calif.

Scarlet Fever Streptococcus Antitoxin Concentrated Globulin—P. D. & Co. (New and Nonofficial Remedies, 1926, p. 332). The product is now prepared by the method of Drs. Dick. This product is also marketed in single 1 c.c. vial packages (for the diagnostic blanching test). Parke, Davis & Co., Detroit, Mich. (Jour. A. M. A., Dec. 11, 1926, p. 1999.)

Homocamfin—Cyclosal — 3-methyl-5-isopropyl-△2-cyclohexanone dissolved in an aqueous solution of sodium salicylate. Methylisopropylcyclohexanone, the potent constituent of homocamfin, is claimed to have an action similar to camphor, but to surpass it in intensity and rapidity of action on the heart and respiration. It acts almost instantly when given intravenously, hence caution must be used when it is administered in this way. Homocamfin is used as a stimulant in cardiac failure, surgical shock, narcotic poisoning and respiratory failure. The product is marketed in Ampules Homocamfin 10 per cent (for intramuscular use) and Ampules Homocamfin 1 per cent (for intravenous use). Winthrop Chemical Co., Inc., New York.

Tutocain. Butamin—p-amino-benzoyldimethylaminomethyl-butanol hydrochloride. Tutocain is a local anesthetic employed chiefly for surface anesthesia and by subcutaneous injection. In experiments made for the Council, Tutocain in 3 per cent solution is about four times as toxic as procaine hydrochloride by rapid intravenous injection into the cat and a fatality has been reported following the injection of 8 c.c. of a 2 per cent solution into the urethra. On the other hand, experiments and clinical trials have been reported in support of the claim that Tutocain is relatively safe for use in surface anesthesia and by hypodermic injection. Tutocain is marketed as: Tablets Tutocain No. 1 (with Epinephrin) containing 0.03 gm.; Tablets Tutocain No. 2 (with Epinephrin) containing 0.05 gm.; Tablets Tutocain No. 3 containing 0.03 gm.; Tablets Tutocain No. 4 (with Epinephrin) containing 0.05 gm.; Tablets Tutocain No. 5, containing 0.1 gm. Winthrop Chemical Co., Inc., New York. (Jour. A. M. A., Dec. 18, 1926, p. 2093.)

Diphtheria Toxin-Antitoxin Mixture 0.1 L+. Each c.c. of the Diphtheria Toxin-Antitoxin Mixture (New and Nonofficial Remedies, 1926, p. 333) represents 0.1 L+ dose of diphtheria toxin neutralized with the required amount of antitoxin. The product is marketed in packages of three 1 c.c. vials for one immunization; in packages of thirty 1 c.c. vials for ten immunizations; in packages of one vial containing 50 c.c. Cutter Laboratory, Berkeley, Calif.

Pirquet Test. Tuberculin—Koch (New and Nonofficial Remedies, 1926, p. 344) marketed in packages of three capillary tubes. Eli Lilly & Co., Indianapolis.

Tuberculin Ointment for the Moro Percutaneous Test. Tuberculin—Koch (New and Nonofficial Remedies, 1926, p. 344) marketed in the form of an ointment in tubes containing 2 gm.

Old Tuberculin, Human Strain, Concentrated. Tuberculin—Koch (New and Nonofficial Remedies, 1926, p. 344) marketed in 1 c.c. vials. Eli Lilly & Co., Indianapolis.

Tuberculin, T. R. Concentrated, Human Strain. New Tuberculin T. R. (New and Nonofficial Remedies, 1926, p. 347) marketed in 1 c.c. vial packages. Eli Lilly & Co., Indianapolis.

Tuberculin, B. E. Concentrated, Human Strain. New Tuberculin B. E. (New and Nonofficial Remedies, 1926, p. 347) marketed in 1 c.c. vials. Eli Lilly & Co., Indianapolis.

Tuberculin, B. F. Concentrated, Human Strain. Tuberculin Denys (New and Nonofficial Remedies, 1926, p. 349) marketed in 1 c.c. vials. Eli Lilly & Co., Indianapolis.

Plague Vaccine, Prophylactic. Plague bacillus vaccine (New and Nonofficial Remedies, 1926, p. 354) marketed (for single vaccinations) in packages of two 1 c.c. vials; in packages of ten 1.5 c.c. vials; in packages (for double vaccinations) of one 20 c.c. vial; in packages of three 1 c.c. vials. Eli Lilly & Co., Indianapolis.

Cholera Vaccine, Prophylactic. Cholera vaccine (New and Nonofficial Remedies, 1926, p. 351) marketed in packages of three 1 c.c. vials; in packages of ten 2.5 c.c. vials. Eli Lilly & Co., Indianapolis. (Jour. A. M. A., Dec. 25, 1926, p. 2163.)

Bar-Che-Co.—The price list of Barksdale Chemical Co., successors to the Webster-Warnock Chemical Co., Memphis, Tenn., presents the usual pills, elixirs, tinctures, etc., and the inevitable assortment of irrational shotgun "specialties." A booklet and form letter feature "Bar-Che-Co," "the mighty aphrodisiac," recommended for "its therapeutical value in the treatment of Neurasthenic impotence." The preparation is claimed to contain "Yohombine (Yohimbine?) hydrochloride," 1/12 gr., "Extract Nux Vomica," 1/6 gr., "Lecithin," 1/8 gr., "Pituitary Substance," 1/24 gr.. "Thyroid Substance," 1/12 gr., "Suprerenal (Suprarenal?) Substance," 1/5 gr. This is a typical shotgun mixture, and is open to all the objections that have been made to this discredited style of therapy. (Jour. A. M. A., Dec. 18, 1926, p. 2114.)

Clearwater's Rheumatic Treatment. In the village of Hallowell, Maine, there has been conducted for some years a piece of mail-order quackery by one H. P. Clearwater, a man without medical training. Clearwater has a somewhat extensive line of nostrums, some of which are sold exclusively on the mail-order plan, while in the sale of others, Clearwater splits profits with drug stores. Clearwater's mail-order activities are mainly with his alleged cure for rheumatism "Clearwater's Scientific Rheumatic Treatment." From an analysis made in the A. M. A. Chemical Laboratory it appears that the "treatment" consists of two kinds of laxative tablets, one of which has in addition: Sodium iodide 1/3 grain and sodium carbonate 5 grains per tablet. (Jour. A. M. A., Dec. 18, 1926, p. 2112.)

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10. a. Define hernia.
b. Name common herniae.
c. What is strangulated hernia?
d. What is traumatic hernia?

ANATOMY

WILBUR N. LINN, M.D., *Examiner*

1. Discuss the general subject of bursae (structure and function).

2. Describe diaphragm.

3. What is the function of the sterno-cleido mastoid muscle; the sartorius; pouparts ligament; semilumar valve?

4. Briefly describe the temporal bone and give its articulations.

5. What structures are supplied by the median, the pneumogastric, the fourth cranial and the crural nerve?

6. Name the regions of the abdomen and give structures lying within their boundaries.

7. What muscles are involved in paralysis of the ulnar nerve?

8. Give blood and nerve supply of thyroid gland and dangers of operation on the gland.

EAR, EYE, NOSE AND THROAT

WILBUR N. LINN, M.D., *Examiner*

1. Given a case of penetration of the eye-ball by a foreign body, what procedure would you follow and what complications might develop? Outline general treatment.

2. Describe a case of acute mastoiditis giving etiology, pathology and treatment.

3. What is the function of the nose? The accessory sinuses. The turbinate bones.

4. Differentiate Vincent's angina. Diphtheria and scarlatinal sore throat.

OBSTETRICS

EDITH HAIGH-STEVENS, M.D., *Examiner*

1. Diet—its influence on parturition.

2. Discuss anesthesia during the period of parturition.

3. What do you advise about exercise during pregnant period?

4. What can you do to limit the pernicious vomiting of pregnancy?

5. Discuss changes in breasts and nipples during pregnancy.

6. Describe pathological condition of the mammae after delivery and suggest treatment.

7. Discuss premature infant, and how to handle him.

GYNECOLOGY

EDITH HAIGH-STEVENS, M.D., *Examiner*

(Write on 4 questions.)

1. Carcinoma mammae—tell what you can of diagnosis, aside from laboratory findings.

2. What are the two climacteric periods in the sex life of a woman?

Give physiological changes.

3. Discuss metrorrhagia at menopause with reference to the involvement of great abdominal organs.

4. Discuss sterility.

5. Discuss pruritus vulvae.

THERAPEUTIC NOTES

NEW AND NONOFFICIAL REMEDIES

In addition to the articles enumerated previously, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Robert A. Bernard:
Saf-T-Top Mercurochrome Solution 2 c.c.

Kansas City Oxygen Gas Co.:
Ethylene for Anesthesia (Kansas City Oxygen Gas Co.)

Eli Lilly & Co.:
Erysipelas Streptococcus Antitoxin—Lilly (Concentrated Globulin).

Parke, Davis & Co.:
Antistreptococcus Serum 20 c.c. piston syringe.
Antistreptococcus Serum 50 c.c. piston syringe.

Swan-Myers Co.:
Arizona Ash Concentrated Pollen Extract—Swan-Myers; Crab Grass Concentrated Pollen Extract—Swan-Myers; Goose Grass Concentrated Pollen Extract—Swan-Myers; Mountain Cedar Concentrated Pollen Extract—Swan-Myers; Ox-Eye Daisy Concentrated Pollen Extract—Swan-Myers; Plantain Concentrated Pollen Extract—Swan-Myers; Yellow Fox-Tail Concentrated Pollen Extract — Swan-Myers.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

Gynergen—Ergotamine Tartrate. The normal tartrate of the principal alkaloid of ergot. Gynergen stimulates the motor nerve endings of the sympathetic division of the autonomic nervous system, thus causing an increase in blood pressure, contraction of the uterus, etc. It is proposed for use when the action of ergot to produce uterine contractions is desired. It is contraindicated when a tonic contraction of the uterus is undesirable. Gynergen is administered intramuscularly or hypodermically, and orally. The product is supplied in the form of Ampules Gynergen, 1.1 c.c. and Tablets Gynergen, 0.001 gm. H. A. Metz Laboratories, Inc., New York.

Ampoules Glucose (Dextrose, U.S.P.) Lilly 10 gm., 20 c.c. Each ampule contains Dextrose, U.S.P., 10 gm. cresol, 0.1 per cent and distilled water to make 20 c.c., buffered with sodium phosphate. Eli Lilly & Co., Indianapolis.

Ampoules Glucose (Dextrose, U.S.P.) Lilly 25 gm., 50 c.c. Each ampule contains Dextrose, U.S.P. 25 gm., distilled water to make 50 c.c., accompanied by an ampule containing 2 c.c. of a buffer solution. Eli Lilly & Co., Indianapolis. (Jour. A. M. A., Jan. 8, 1927, p. 101.)

Ethylene for Anesthesia. It contains not less than 98 per cent by volume of ethylene. Trials on human subjects have confirmed the anesthetic and analgesic value of ethylene as demonstrated by animal experiments. Deep surgical anesthesia is stated to be produced easily, and analgesia comes on readily and apparently long be-

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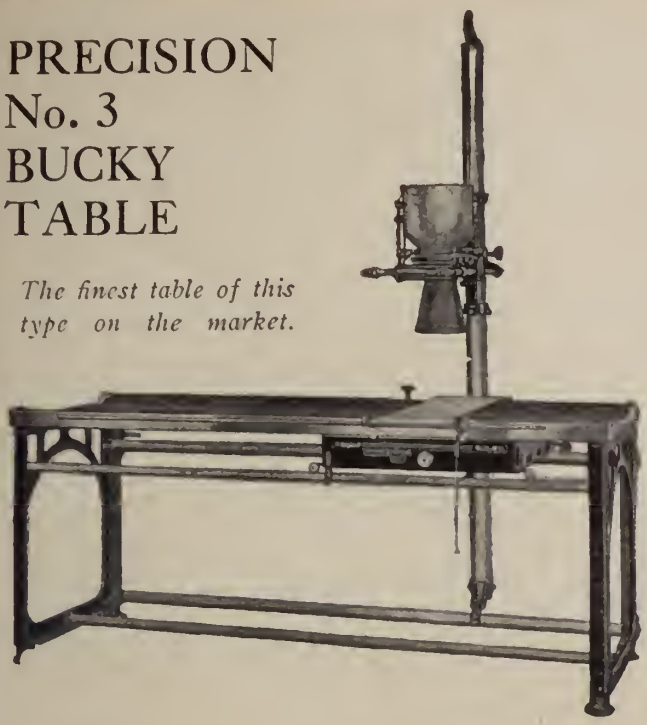

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The flat grid Bucky Diaphragm illustrated is the latest development in this type of equipment and offers many improvements and many features hitherto not available. Its many advantages over the curved grid type are self-evident.

It eliminates the difficulties previously encountered of the patient's body being out of normal position, and of the film being too far from the body. It simplifies centering the patient.

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fore anesthesia is established. A considerable number of trials give promise that ethylene is of value for the production of surgical anesthesia and that it has advantages over nitrous oxide. Ethylene for anesthesia is supplied in compressed state in metal cylinders.

Ethylene for Anesthesia (Kansas City Oxygen Gas Co.) A brand of ethylene for anesthesia—N. N. R. Kansas City Oxygen Gas Co., Kansas City, Mo. (Jour. A. M. A., Jan. 29, 1927, p. 323.)

PROPAGANDA FOR REFORM

The following products have been the subject of prosecution by the federal authorities charged with the enforcement of the Food and Drugs Act: Glycero-Celery Tonic (Brunswig Drug Co.), consisting of potassium bromide, glycerin, extracts of plant drugs, sugar, alcohol, and water. T.S.B. Liverclean (C. M. and R. Tompkins), essentially Glauber's salts, Epsom salts, sugar and a trace of plant extract dissolved in water. Womanette (Capital Remedy Co.), consisting of potassium bromide, extracts of plant drugs (including sassafras), alcohol, water and a trace of a salicylate. Sirup of Ambrozoin (American Apothecaries Co.), consisting essentially of ammonium chloride, sodium and potassium bromides, small amounts of plant extracts, a trace of creosote, benzoic acid, alcohol, sugar and water. Angelus Compound Sirup of Hypophosphites (Brunswig Drug Co.), consisting of sodium, iron, manganese, quinine and strychnine hypophosphites, traces of calcium and potassium salts, glycerin, sugar and water. Brunswig's Compound Fluidextract Buchu (Brunswig Drug Co.), consisting essentially of potassium acetate, extracts of plant drugs, glycerin, alcohol and water. Allen's Lung Healer (H. J. Allen Co.), a partly emulsified mixture of mineral oil, about 30 per cent, volatile oils, including anise oil, about one-half of 1 per cent, extracts of plant drugs, including licorice, sanguinaria, benzoic acid, sugar and water. Whitlock's U-GR-GL (Cherokee Remedy Co.), essentially a dilute, watery solution of washing soda flavored with menthol. (Jour. A. M. A., Jan. 1, 1927, p. 48.)

The Lead Treatment of Cancer.—At a recent meeting of the British Medical Association, a full summary of the results to date was presented by members of the staff of the Liverpool Medical Research Organization. The clinical survey indicates that there is promise of therapeutic benefit in a few selected cases of otherwise hopeless cancer. The preliminary task before treatment can be begun is the selection of patients who may possibly obtain benefit. The lead suspension which Blair Bell uses contains fairly fine particles, some of which are metallic lead, and some lead hydroxide and lead carbonate. The mixture is more toxic than pure colloidal lead but it is also more effective in the destruction of tumors. Commercial products are not as yet available, but several laboratories in this country and in England are experimenting with various preparations, hoping soon to be able to develop a standardized and reliable product. It seems that Blair Bell has shown that when employed under cited limitations and by those who possess proper laboratory facilities and clinical experience, lead therapy offers to a small number of persons affected with inoperable tumors, a chance to escape the consequences of the disease. But before any widespread use can be made of the method, some means of removing lead from the body to control acute or chronic poisoning should be developed. The whole situation is thus frankly in the experimental stage. To carry out the treatment at all, requires hospitalization of the patient for some months, laboratory and clinical facilities not everywhere available and funds for frequent transfusions. It seems improbable that the method will ever replace surgery or compete with irradiation, but it has already accomplished something in patients in whom one or both of these procedures had failed. (Jour. A. M. A., Jan. 8, 1927, p. 103.)

Nonspecific Protein Administration. The intravenous injection of typhoid vaccine with an initial dosage of 50 millions, each subsequent dose increased by 100 millions, and given at four day intervals, is one of the most reliable means of producing fever. It is a drastic measure and one should be certain that the patient's vital organs are sufficiently healthy to withstand the attacks of fever thus produced. The intramuscular injection of milk skimmed by centrifugalizing and sterilized by boiling in the water bath for ten minutes, has good pyrogenic properties without great toxicity. The usual dose is 5 c.c., gradually increased to 10 c.c. With those who have a tendency to strong febrile reactions, small doses should be given at first. The injections must be adjusted to avoid severe reactions and anaphylactic shock. (Jour. A. M. A., Jan. 8, 1927, p. 119.)

Kloron. Qualitative tests made in the A. M. A. Chemical Laboratory indicate that Kloron Tablets (J. I. Holcomb Mfg. Co.) contain Chloramine—U.S.P. as their potent ingredient. The claims made for the preparation are typical of the extravagant exploitation of official products by the "patent medicine" route. (Jour. A. M. A., Jan. 8, 1927, p. 119.)

Sodium Bromide Intravenously. Sodium bromide may be injected intravenously provided the liability of such an injection causing colloidoclastic shock is reckoned with. It seems, however, that mere "gastric distress" would call for better dilution of the dose given by mouth, as with a tumblerful of milk, or for introduction by way of the rectum, rather than intravenous injection. (Jour. A. M. A., Jan. 8, 1927, p. 120.)

Cass Treatment for Rheumatism. One hundred and thirty-seven West Sixty-Second Street, Chicago, houses a choice line of quackery. Under the names "Western Medical Association" and "Vernon Laboratories" a fake "epilepsy cure" is exploited on the mail order plan. Under the name "Cass Laboratories," nostrums for rheumatism, sciatica, neuralgia, lumbago and gout are sold—also through the United States mails. The A. M. A. Chemical Laboratory reports that the "Cass Treatment" consists of pink tablets, "Special Saline Compound" and gray tablets. The Laboratory found the pink tablets to contain 0.6 gm. of sodium bicarbonate per tablet. The "Special Saline Compound" was found to be essentially flavored magnesium sulphate. The

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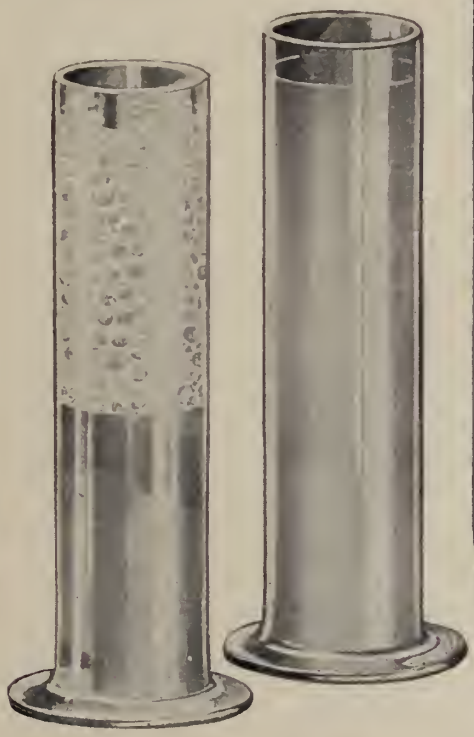

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gray tablets were found to contain essentially .16 gm. acetylsalicylic acid, 0.13 gm. cinchophen and 0.3 gm. charcoal per tablet. From the Laboratory's report it is seen that this wonderful discovery "developed under the direction of the Head Professor of Chemistry at one of the nation's largest universities," and declared by "two of the foremost medical scientists in this country" to be superior to anything else in its line, is merely a combination of acetylsalicylic acid and cinchophen with sodium bicarbonate and magnesium sulphate. (Jour. A. M. A., Jan. 15, 1927, p. 189.)

Physical Therapy and Pseudophysics. Much of the literature on physical therapy has apparently been written with an eye to the royalty statement or the publicity returns rather than to the possibility of scientific criticism. These treatises become impressive, in size, at least, by the inclusion of statements on the physics of the apparatus culled almost in toto from the advertising and descriptive matter published by a manufacturer. This practice might be commendable if the physical concepts were not often wholly at variance with the concepts generally accepted by physicists. The physician who desires a substantial knowledge of physical therapy must choose his sources of information carefully. (Jour. A. M. A., Jan. 15, 1927, p. 175.)

Diamel in Diabetes. Diamel tablets are manufactured by the Maltbie Chemical Co. They are stated to contain "Lithium Carbonate 1½ grs.; Sodium Arsenate 1/20 gr.; Strychnine Arsenate 1/180 gr.; Ext. Jambul Seed ½ gr.; Ext. Gentian ½ gr." The product is marketed with the claim: "This tablet is employed for the reduction and elimination of sugar in the urine, which it is said to do rapidly. A trial will speedily prove the efficiency of this formula." None of the components of Diamel tablets have any specific effect on the course of diabetes. (Jour. A. M. A., Jan. 22, 1927, p. 267.)

I-on-a-co—The Magic Horse Collar. California was not satisfied when it gave us the greatest piece of quackery, the electronic reactions of Abrams. Now we are treated to another piece of electrical hocus-pocus which comes from California: I-on-a-co, alleged to have been invented by one Gaylor Wilshire, and exploited by the I-on-a Company of Los Angeles. The device, one gathers from the advertising, will cure cancer, Bright's disease and paralysis, change gray hair back to black and give girls who use it a "permanent wave." A committee which investigated the device, reported that I-on-a-co is simply a coil of insulated wire about 18 inches in diameter with a plug that permits the coil to be attached to an electric light socket. There is also a smaller coil that plays no part in the alleged curative use of the I-on-a-co, but plays an all-important part in the magical features of the scheme. This coil has its two ends attached to a miniature light socket containing a small flashlight globe. When the larger coil is plugged into an alternating current electric light socket there is, of course, generated within the large coil a weak fluctuating magnetic field. This will cause the globe in the small coil to light up when it is brought in close proximity to the large coil. This phenomenon, while elementary to a degree, furnishes for the uninitiated that element of mystery which is so necessary to the successful exploitation of any alleged cure for human ailments. The I-on-a-co is used by placing this magnetic horse collar over the neck, around the waist or around the legs of the person who thinks he is going to be helped by a piece of buncombe of this sort. (Jour. A. M. A., Jan. 22, 1927, p. 262.)

Sale of Ultraviolet Generators to the Public. The Council on Physical Therapy, on the basis of the available evidence, contends that the sale of generators of ultraviolet energy to the public for self-treatment is without justification. The Council bases its condemnation of the sale of such apparatus on the ground that harm may result from such use by the public; because unwarranted confidence in the therapeutic value of treatment with such apparatus may lead to attempts to treat serious conditions; because the possessor of such apparatus would fail to obtain a correct diagnosis of his condition; and because the practice would encourage the sale of useless and fraudulent apparatus. (Jour. A. M. A., Jan. 22, 1927, p. 245.)

Spahlinger Treatment of Tuberculosis. Notwithstanding the fact that the Spahlinger treatment of tuberculosis was secret and that evidence in its favor had not been made generally available, Spahlinger and his friends have repeatedly attempted to secure government endorsement of the preparation in England and to secure funds for its development. Now the records of ten patients injected by Spahlinger personally with this remedy have been reported by Dr. Thomas Nelson in the London Lancet. These records are decidedly unfavorable to the treatment. The evidence in favor of the Spahlinger method of treatment of tuberculosis is not sufficient at this time to warrant an extensive trial. The burden of proof is still on Spahlinger, who should at least show that in a considerable number of cases studied under controlled conditions the remedy will accomplish more than can be accomplished by the method of treatment now practiced in well regulated institutions for the treatment of tuberculosis. (Jour. A. M. A., Jan. 22, 1927, p. 248.)

Chemical Examination of Ethylene for Anesthesia. In consideration of the recently reported deaths from ethylene anesthesia, the A. M. A. Chemical Laboratory decided to reexamine the brand of ethylene for anesthesia accepted for New and Nonofficial Remedies, namely that of the Ohio Chemical and Manufacturing Co. As the Kansas City Oxygen Gas Co. had just submitted its product to the Council, this brand was also examined. The brand of ethylene which was used in the fatal cases was not examined and is not one of the brands reported on. The specimens were examined according to the methods of New and Nonofficial Remedies and in addition submitted to a more delicate test for carbon monoxide. They met the standards and in none was carbon monoxide found to be present. The Laboratory recommends that physicians use only the brands of ethylene which stand accepted for inclusion in New and Nonofficial Remedies. (Jour. A. M. A., Jan. 29, 1927, p. 322.)

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mon disease than is generally believed. Pathologists will bear out this statement. The article from Dr. Arthur R. Elliott's clinic is thus very timely and he has stressed its similarity to acute lobar pneumonia of non-tuberculous origin. A careful history will often provide the key to the situation.

Dr. Walter S. Priest advocates a routine basal metabolism test in all heart cases as cases of thyroid heart without goiter or exophthalmos are often missed.

A warning to physicians who use toxin-antitoxin mixture is given by Dr. Jesse Gerstley who cites a fatal case in a child of seven following the use of this agent. It is suggested that a preexistent nephritis may have been the cause of death in this case although there were other unexplained factors.

Dr. Pilot describes three cases of pulmonary complications in diabetes due to fusospirochaetal infections. These anaerobes are frequently the cause of such conditions in ordinary lung abscess and empyema following tonsillectomy and exodontia. As arsenic has great therapeutic value in fusiform infections the diagnosis is doubly important.

Many other interesting articles appear in this issue which are well up to standard.—W. J. E.

Medical Clinics of North America. Volume IX, Number VI, Chicago number, May, 1926. Octavo of 202 pages including complete index to Volume IX, with 24 illustrations. Per clinic year, July, 1925, to May, 1926: Paper, $12.00; cloth, $16.00, net. W. B. Saunders Company, Philadelphia and London.

We took up this book with the intention of reading an article or two, but it is not the kind of book that one lays by unfinished. Yet these clinics are not to be gone over in a single evening; they are worthy of deeper study. We are impressed once again by the remarkable superiority of the clinical method over that of the textbook or "system."

This volume contains a timely clinical study by Dr. Hamill—*Disability, Damages, or Disease*—most valuable to anyone engaged in practice, as touching quite fully upon the importance of a thorough study of industrial accident cases. More than this, real, virile principles of the handling of such cases are lucidly expressed.

Dr. Pollock presents *Neurologic Diagnosis*, a brief, most clear résumé of a maligned subject. He emphasizes the futility of attempting to memorize each nervous disease as a collection of symptoms and signs, and approaches his subject from an entirely different and entirely rational angle. Directly in line with his clinic is that of Dr. Holmes, who presents neurologic cases. One of these is a case of *compression tardive* (chronic subdural hemorrhage), and the discussion of symptoms, their explanation, and the reasons for suggesting that this disease is one with pachymeningitis hemorrhagica interna, we consider truly masterful.

Dr. Singer presents a valuable clinic in diseases of the stomach—*Some Complicated and Uncommon Gastric Lesions.* He mentions especially the common fallacy of carelessness—the idea that ulcer and cancer constitute the whole of gastric diseases. He presents a case of polypoid gastritis complicated by ulcer and carcinoma, the cancer not arising from the ulcer, but remote from it, and diagnosticated only by microscopic examination of the resected organ. The clinician fails to recognize this finding as bearing any reference to the newer theory that gastric cancer never arises from an ulcer. A further study of gastric carcinoma is found in the clinic of Drs. Brams and Wolf-Blitzsten, who present a case where the cancer was discovered only by the presence of occult blood in the centers of formed stools, which blood was present still after an ulcer had been apparently cured by Sippy's method.

We have not mentioned the clinic of Drs. Hess and Rosenblum—a most instructive consideration of gastroenteric hemorrhage in children; nor Dr. Strauss' clinic on the hemorrhagic blood dystrophies.

We are of Stedman's frame of mind, and consider no review complete without mention of style. In a day when quality of scientific writing is too frequently sacrificed to quantity, it is a real pleasure to discover a book that is, on the whole, so well written.—W. J. E.

STATE SOCIETY RESEARCH ON PROPOSED X-RAY LICENSE

(Continued from Page 231.)

Shall Technicians Be Licensed To Diagnose?

When we come to the question of whether technicians shall not only be licensed as such but shall also have legislative authority to make a diagnosis, our investigation convinces us that such procedure would not only be dangerous to the individual patient but would be dangerous to the public health as a whole. In addition to all the reasons why technicians should not be licensed as such we find:

1. A survey of manufacturers discloses the fact that according to best estimates there are now from 400 to 600 x-ray machines in the hands of physicians and hospitals of the state. We feel it is safe to estimate that there would be several hundred technicians applying for license without examination on the grounds that they were practitioners before the law was enacted and were entitled to the exemption provided in the bill for them. We do not feel that a technician licensed by the mere fact that he is a prior practitioner of a year or even four years' experience is possessed of the fundamental knowledge that would permit him to do even a bare justice to his patients in making a diagnosis. Should such prior practitioners become licensed the public would rightfully assume that the mere word "Licensed" meant that they possessed education and ability for which we have

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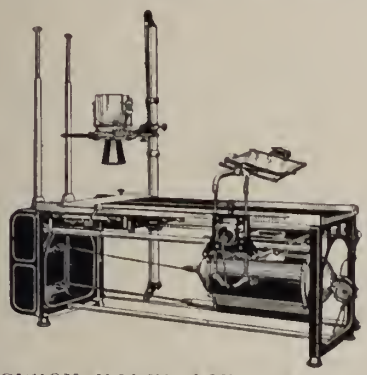

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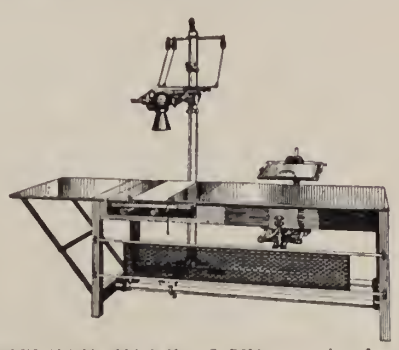

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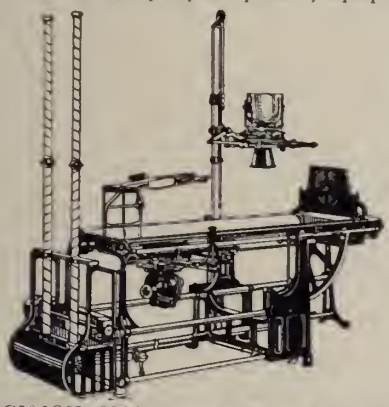

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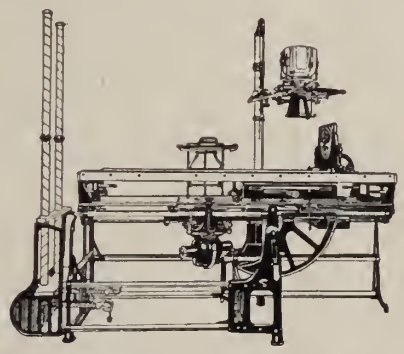

PRECISION MODEL 1-1FB, the first Radiographic and Fluoroscopic Combination Table to be designed which incorporates a Bucky Diaphragm. With this table it is possible to make a complete X-ray examination without moving the patient from the table. It is capable of being adjusted for any position from the Trendelenburg to the vertical with great ease. An ideal apparatus for the laboratory where space is limited.

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no assurance of existence and, on the whole, positive assurance of non-existence.

2. Further, we call attention to the fact that only in certain types of cases is the x-ray a self-sufficient standard of diagnosis. We call attention to the case cited by the New York City Board of Health in which they point out the fact that a diagnosis of tuberculosis and its activity cannot be made from the x-ray film alone but must include other tests and the history and appearance of the patient. As they so well point out, an error in diagnosis may not only condemn a tuberculous patient to an early end but may also result in a spread of the disease.

Shall Technicians Be Licensed To Treat?

In view of what has been previously pointed out we feel that little more needs be said to demonstrate that a technician should not be licensed to treat disease by means of the x-ray. We simply state the known and recognized fact that treatment by the x-ray cannot be standardized. Treatment depends not only upon a correct diagnosis of the disease but a high degree of judgment, based upon long education and experience, in determining whether treatment by the x-ray would be more, or less, beneficial than treatment by some other known means. When used with the greatest degree of judgment and skill the x-ray may be a potentiality for much good. But its use for treatment in many cases is fairly comparable to major surgery. Knowledge of how to dissect does not make a surgeon and knowledge of how to operate an x-ray machine does not make a roentgenologist.

Conclusion

In the compilation of this report a special committee of the State Medical Society of Wisconsin has endeavored to obtain evidence and information from every source available. These sources are listed herewith. No attempt was made to arrive at any conclusion until the entire information was before us and even then we held a special meeting with proponents of the bills at our expense that we might hear evidence from every angle. Our conclusions herein listed were arrived at on March 14, 1927.

Our conclusions may be summarized in the statement that,

1. We do not believe that any legislation is necessary to assure the public proper protection from those who, in the future, may be licensed to treat the sick and who may use the x-ray for diagnosis or treatment as their license may permit.

2. We do not believe that any measure which licenses x-ray technicians either to treat, diagnose or merely operate an x-ray machine is in the public interest.

We therefore recommend no legislation in this field.

Respectfully submitted,
George Crownhart, *Secretary,*
State Medical Society of Wisconsin.
For the Committee.

COMMITTEE ON PUBLIC POLICY:
O. B. Bock, M.D., Sheboygan.
D. L. Dawson, M.D., Rice Lake
J. J. McGovern, M.D., Milwaukee.

SPECIAL SUB-COMMITTEE:
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Francis Mackoy, M.D., Milwaukee.
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Sources of Information

Mr. John McIntosh, Wisconsin Manager, Victor X-Ray Corporation.

Mr. H. E. Pengelly, Pengelly X-Ray Company.

Dr. Otto Foerster, Professor of Dermatology, University of Wisconsin.

Medical Protective Insurance Company of Fort Wayne, Indiana.

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Dr. N. P. Colwell, Council on Education, American Medical Association.

Dr. H. H. Meusel, President, Oshkosh Clinic, Oshkosh.

Dr. L. T. LeWald, Professor of Roentgenology, University and Bellevue Hospital Medical College, New York City.

Dr. Frederick H. Baetjer, Professor of Clinical Roentgenology, Johns Hopkins University, Baltimore, Md.

Dr. H. B. Podlasky, Associate Professor Clinical Roentgenology, Marquette University School of Medicine, Milwaukee.

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¶It is also desirable that the diversions and entertainment be carefully supervised so that it is given at the proper times, be of the proper type and not too much or too little.

¶These facilities are available at Mounds Park Sanitarium, which is a general hospital with a specialized psychopathic department.

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Dr. B. C. Cushway, President, 1926, Radiological Society of North America, Chicago.

Dr. M. J. Hubeny, Editor of "Radiology," Chicago.

Mr. J. R. Bruce, Executive Secretary, American Registry of Radiological Technicians, St. Paul, Minn.

THERAPEUTIC NOTES

NEW AND NONOFFICIAL REMEDIES

In addition to the articles enumerated previously, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Eli Lilly & Co.:
- Ricinoleated Antigen, Scarlet Fever, Immunizing—Lilly.

National Aniline & Chemical Co.:
- Tablets Gentian Violet Medicinal—"National," 0.0324 gm. (½ grain).
- Enteric Coated Tablets Gentian Violet Medicinal—"National," 0.0324 gm. (½ grain).

Parke, Davis & Co.:
- Glaseptic Ampoules Sodium Cacodylate—P. D. & Co.—
  - Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., 0.5 gm. (¾ grain), 1 c.c.
  - Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., 0.10 gm. (1½ grains), 1 c.c.
  - Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., 0.13 gm. (2 grains), 1 c.c.
  - Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., 0.20 gm. (3 grains), 1 c.c.
  - Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., 0.3 gm. (5 grains), 1 c.c.
  - Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., 0.45 gm. (7 grains), 1 c.c.
  - Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., 1 gm. (15 grains), 2 c.c.
  - Glaseptic Ampoules Sodium Cacodylate—P. D. & Co. (For Intravenous Use), 0.20 gm. (3 grains), 5 c.c.
  - Glaseptic Ampoules Sodium Cacodylate—P. D. & Co. (For Intravenous Use), 0.45 gm. (7 grains), 5 c.c.
  - Glaseptic Ampoules Sodium Cacodylate—P. D. & Co. (For Intravenous Use), 1 gm. (15½ grains), 10 c.c.

Swan-Myers Co.:
- Cosmos Concentrated Pollen Extract—Swan-Myers; Dandelion Concentrated Pollen Extract—Swan-Myers; Palmer's Amaranth Concentrated Pollen Extract—Swan-Myers.

The United Laboratories:
- Culture Bacillus Acidophilus—United Laboratories.

Nonproprietary Articles:
- Ricinoleated Scarlet Fever Antigen.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

Saf-T-Top Mercurochrome Solution. An aqueous 2 per cent solution of mercurochrome—220 soluble (New and Nonofficial Remedies, 1926, p. 249) in ampules containing 2 c.c. and having a capillary opening. Robert A. Bernhard, Rochester, N. Y.

Bismuth Salicylate in Oil—P. D. & Co. A suspension of bismuth salicylate U. S. P. (New and Nonofficial Remedies, 1926, p. 97) in a liquid composed of camphor, 10 per cent; creosote, 10 per cent; olive oil, 80 per cent. Each c.c. contains bismuth salicylate, 0.13 gm. (2 grains). Parke, Davis & Co., Detroit.

Glaseptic Ampules Bismuth Salicylate in Oil—P. D. & Co., 1 c.c. Each ampule contains 1 c.c. of a suspension of bismuth salicylate U. S. P. (New and Nonofficial Remedies, 1926, p. 97) 0.13 gm. (2 grains) in a liquid composed of camphor, 10 per cent; creosote, 10 per cent; olive oil, 80 per cent. Parke, Davis & Co., Detroit.

Concentrated Pollen Extracts—Swan-Myers. In addition to the products listed in New and Nonofficial Remedies, 1926, p. 28, the following have been accepted: Cosmos Concentrated Pollen Extract—Swan-Myers; Dandelion Concentrated Pollen Extract—Swan-Myers; Palmer's Amaranth Concentrated Pollen Extract—Swan-Myers. Swan-Myers Co., Indianapolis.

Erysipelas Streptococcus Antitoxin—Lilly (Concentrated Globulin). An erysipelas streptococcus antitoxin (Jour. A. M. A., August 28, 1926, p. 671) obtained by injecting horses subcutaneously with strains of hemolytic streptococci obtained from Dr. A. R. Dochez from human cases of erysipelas lesions, bleeding the horses, and when test bleedings show the serum to have reached the desired potency, bleeding as plasma which is concentrated and refined. Marketed in syringe containers (therapeutic dose) containing 5,000 "units." Eli Lilly & Co., Indianapolis. (Jour. A. M. A., Feb. 5. 1927, p. 403.)

Antistreptococcic Serum (New and Nonofficial Remedies, 1926, p. 339). This product is also marketed in 20 c.c. and 50 c.c. piston syringes. Parke, Davis & Co., Detroit.

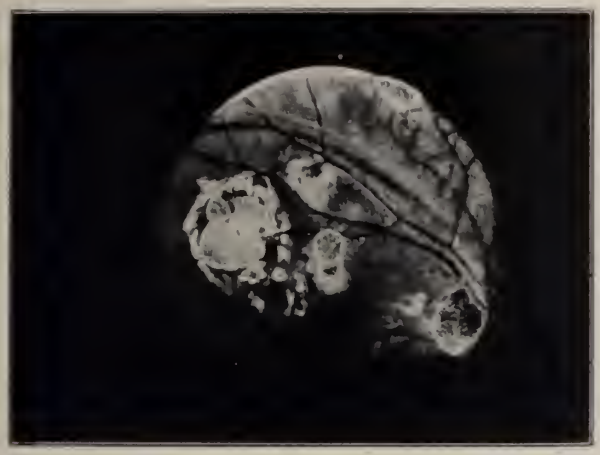
Tablets Gentian Violet Medicinal—"National," 0.0324 gm. (½ grain). Each tablet contains Gentian Violet Medicinal—"National" (New and Nonofficial Remedies, 1926, p. 167), 0.0324 gm. (½ grain). National Aniline and Chemical Co., New York.

Enteric Coated Tablets Gentian Violet Medicinal—"National," 0.0324 gm. (½ grain). Each tablet contains Gentian Violet Medicinal—"National" (New and Nonofficial Remedies, 1926, p. 167) 0.0324 gm. (½ grain) and is coated with phenyl salicylate containing some keratin. National Aniline and Chemical Co., New York.

Ricinoleated Scarlet Fever Antigen. A bacterial vaccine detoxified with sodium ricinoleate according to the method of Dr. W. F. Larson. Enough favorable evidence has accumulated to indicate that this preparation is worthy of clinical trial by physicians. The antigen is used for active immunization against scarlet fever.

Ricinoleated Scarlet Fever Antigen Immunizing—Lilly. This product is prepared from whole broth cultures of scarlet fever streptococci, containing 1,000 million organisms in each c.c., modified with 2 per cent of sodium ricinoleate. It is marketed in 1 c.c., 5 c.c. and

Central Choroiditis of the Left Eye



This illustration is made from an enlargement of a picture taken with the Zeiss Fundus Photographing Ophthalmoscope.

Are you taking advantage of our service on this instrument?

Let us send you complete information on instruments and equipment, and our personalized prescription service.

Exclusive Opticians for Oculists

UHLEMANN OPTICAL CO.

Mallers Bldg.
CHICAGO, ILL.

Established 1907

Stroh Bldg.
DETROIT, MICH.

There is just so much real worth built into any scientific instrument — So much accuracy — So much reliability — So much freedom from expensive upkeep — So much service — So much satisfaction — The most ever built into a blood-pressure instrument is built into the NEW

GUARANTEED BREAKAGE FOR

—removed by a simple pressure of the thumb.

Lifetime
Baumanometer
STANDARD FOR BLOODPRESSURE

AGAINST YOUR LIFETIME!

—cleaned and replaced with ease in twenty seconds!

W. A. BAUM CO., INC. - 100 FIFTH AVENUE - NEW YORK

20 c.c. vials. Eli Lilly & Co., Indianapolis. (Jour. A. M. A., Feb. 19, 1927, p. 567.)

PROPAGANDA FOR REFORM

The Organism of Rheumatic Fever. A report of the isolation of the specific organism causing rheumatic fever has been published and also the results of trials with an antiserum. Streptococcus cardioarthritidis, the name given to the organism which was isolated from the blood culture of only two patients with rheumatic fever, differs in only one respect from the usual nonhemolytic streptococcus. The claim of the relation of the organism to rheumatic fever appears to rest chiefly on the results obtained from treating patients with an antiserum prepared by immunizing a horse with this streptococcus. The case reports are not convincing. Favorable reports with a serum prepared by immunizing horses with cultures of streptococci isolated from throats of rheumatic fever patients have been published previously; they were probably due to a non-specific reaction. Since then, curative effects have been reported from the use of various forms of nonspecific protein preparations. (Jour. A. M. A., Feb. 5, 1927, p. 405.)

Ovacoids and Testacoids. The advertising claims made for these preparations of Reed and Carnrick are typical of those made by this firm for products examined by the Council on Pharmacy and Chemistry and denied admission to New and Nonofficial Remedies in 1907. Ovacoids and Testacoids are stated to be "the hormones or autocoids of the sex glands in high concentration, and *active by mouth!*" Ovacoids is stated to "represent the hormones of the entire ovary in highly concentrated form, associated with the hormones of the anterior pituitary and with phosphorus in organic combination." Testacoids are claimed to contain "in addition to the testicular hormones, . . . the hormones of the prostate gland and organic phosphorus." The use of these preparations is irrational and dangerous because the character of the ingredients and their amounts are not declared. The administration of organic phosphorus is not only irrational but superfluous. Though indefinite and semisecret, the composition of Ovacoids and Testacoids is sufficiently specific to place the preparations in the class of pluriglandular mixtures, to the menace of which the Council on Pharmacy and Chemistry has repeatedly called attention. The most important ingredient of Testacoids is apparently a testicular extract. Such preparations are not accepted for New and Nonofficial Remedies and their therapeutic value has not been demonstrated. There is nothing in the claimed composition of Testacoids to furnish a basis for the extensive claims made for the preparation. (Jour. A. M. A., Feb. 5, 1927, p. 422.)

Spengler Treatment of Tuberculosis. The Spengler immune blood treatment of tuberculosis is a method based on the principle of passive immunization. In 1908, Carl Spengler announced his theory that red blood cells play an important part in immunity to tuberculosis, immune substances being contained within the stroma of erythrocytes of the resistant animal. He reported favorable results with his preparation "Spengler's I. K." The method has had only small support. From the published reviews it may be concluded that the method is not of value. (Jour. A. M. A., Feb. 5, 1927, p. 425.)

Ephedrine. The Council on Pharmacy and Chemistry states that the reports which have been issued since its first report was published, warrant the acceptance of the drug for New and Nonofficial Remedies and the recognition of acceptable brands if the firms which market them will agree to be conservative in their claims. The Council report is accompanied by a report of the A. M. A. Chemical Laboratory on the establishment of standards for ephedrine hydrochloride and ephedrine sulphate. The Laboratory's report shows that the ephedrine hydrochloride of the Abbott Laboratories and of Burroughs, Wellcome & Co., meet the provisional standards, but that a pure sulphate has not yet been prepared. However, it appears that the study which is being made in the laboratories of Eli Lilly & Co., gives promise that a satisfactory product will shortly be available. The Council (1) endorsed the report of the A. M. A. Chemical Laboratory and provisionally adopted the submitted standards for ephedrine hydrochloride; (2) it admitted ephedrine to New and Nonofficial Remedies; (3) it voted to accept the ephedrine hydrochloride of the Abbott Laboratories when acceptable advertising is issued; (4) it voted to accept the ephedrine hydrochloride of Burroughs, Wellcome & Co., when it is marketed in the United States and acceptable advertising is issued; and (5) it voted to accept Ephedrine Sulphate—Lilly (formerly called "Fedrin") when the firm has achieved satisfactory standards and when the advertising is found acceptable. (Jour. A. M. A., Feb. 12, 1927, p. 482.)

Some Miscellaneous Nostrums. The A. M. A. Chemical Laboratory reports the analysis of the following: Balzone Treatment for Tuberculosis, exploited by one N. L. Waelchli, Denver, Colorado, appeared to be essentially a little colored water into which a few drops of some volatile oil, similar to pine oil, was to be dropped, the water brought to a boil, and the steam inhaled. Spray-O-Zone, exploited by the Coral Chemical Company, Inc., Buffalo, N. Y., appeared to be essentially borax and potassium chlorate dissolved in water. Boals Rolls, exploited by the Boals Rolls Corporation, New York City, consisted of large tablets found to contain starch, figs and phenolphthalein. Harriet Hubbard Ayer's Face Cream, manufactured by Harriet Hubbard Ayer, New York, was found to contain ammoniated mercury and zinc oxide. (Jour. A. M. A., Feb. 12, 1927, p. 501.)

The "Adjusto" ("Juvenator"). This is another indecent swindle barred from the mails. One G. R. Damiani, who seems to have done business variously under such trade names as G. Lotto, Olds Appliance, Wisett Manufacturing Co., and Sampson Manufacturing Co., all of St. Louis, Mo., have exploited the device called the "Adjusto" and the "Juvenator." Now a fraud order has been issued against the Sampson Manufacturing Company and G. R. Damiani. (Jour. A. M. A., Feb. 12, 1927, p. 501.)

Andrew W. Mellon, one of the wealthiest men in the United States and our present Secretary of the Treasury, once said: "It is essential that we should learn to save, but it is equally important that people generally should learn how to invest their savings in some sound and productive enterprise."

The securities which we offer have been purchased for our own account and have been selected with the view of supplying every investor's need.

We invite your patronage on the basis of the services we are able to render.

Second Ward Securities Co.

Milwaukee

The publishers have made a very attractive book, the illustrations are particularly well done.—*L. M. W.*

Harelip and Cleft Palate Cheiloschisis, Uranoschisis and Staphyloschisis. By Matthew N. Federspiel, D.D.S., M.D. The C. V. Mosby Company, St. Louis.

This book is written after twenty years of hospital and clinical experience, and fifteen years of observation and study of the methods employed by prominent oral and general surgeons for the correction of harelip and cleft palate.

In the introductory chapters, the history, etiology and development of harelip and cleft palate are fully discussed, and there is a further chapter on the types of these deformities.

The treatment of these conditions is considered under two headings: the surgical and the non-surgical. It has been the experience of the author that surgery alone does not always give the hoped for results. In many cases of malrelation of the dental arches and dentofacial deformities, the science of dental orthopedics provides the means for the relief of the condition. The author maintains that the oral surgeon should be familiar not only with oral surgery but also with the principles and technic of orthodontics and prosthetics, as it is only by a combination of methods that satisfactory results can be obtained in many instances. A feature of the author's operation for cleft palate, which he describes fully, is the use of tension plates which he has devised. The non-surgical treatment is fully discussed, and the various types of obturators and artificial vela are given consideration. Here also the author has developed an original method which overcomes the main disadvantages which have attended the use of vela in the past.

One finds the book easy to read. There are 156 illustrations. The drawing is good and not too diagrammatic. The book will take an important place in the literature of this subject, and should be of interest not only to specialists treating this condition, but to embryologists, anatomists and general practitioners as well.—*S. J. S.*

THERAPEUTIC NOTES

NEW AND NONOFFICIAL REMEDIES

In addition to the articles enumerated previously, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories:

Abbott's Mineral Oil Emulsion.

Ephedrine Hydrochloride—Abbott.

Eli Lilly & Co.:

Ephedrine Sulphate—Lilly—

Pulvules Ephedrine Sulphate—Lilly, 0.025 gm.

Pulvules Ephedrine Sulphate—Lilly, 0.05 gm.

Ampoules Ephedrine Sulphate—Lilly, 1 c.c., 0.05 gm.

Solution Ephedrine Sulphate—Lilly, 3 per cent.

E. R. Squibb & Sons:

Scarlet Fever Streptococcus Toxin—Squibb, 1 c.c.

Towt-Nolan Laboratory:

Lactobacillus Acidophilus Milk (Towt).

Nonproprietary Articles:

Ephedrine.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

Concentrated Pollen Extracts—Swan-Myers. In addition to the products listed in New and Nonofficial Remedies, 1926, p. 28, the following have been accepted: Cosmos Concentrated Pollen Extract—Swan-Myers; Dandelion Concentrated Pollen Extract—Swan-Myers; Palmer's Amaranth Concentrated Pollen Extract—Swan-Myers. Swan-Myers Co., Indianapolis. (Jour. A. M. A., March 5, 1927, p. 788).

Ephedrine. Ephedrine is an alkaloid first obtained by Nagai in 1887 from ma huang (*Ephedra equisetina*). Chemically, ephedrine is a-hydroxy-b-methylaminopropylbenzene. Structurally, it is closely related to epinephrine. Its salts are, in general, soluble in water and in alcohol, and the solutions are stable. Ephedrine produces effects similar to those produced by epinephrine. It also has been found to exert a direct depressant action on smooth and cardiac muscle. It produces a rather lasting rise of blood pressure, on intravenous or intramuscular injection, due mainly to vasoconstriction. Thus far, the most definite indications for the usefulness of ephedrine are for its local use on the turbinates and for ophthalmic examinations. Ephedrine has proved effective in some cases of asthma.

Ephedrine Hydrochloride. The hydrochloride of an alkaloid obtained from *Ephedra equisetina*. For a discussion of its actions and uses, see preceding abstract "Ephedrine."

Ephedrine Hydrochloride—Abbott. A brand of ephedrine hydrochloride—N. N. R. Abbott Laboratories, North Chicago, Ill.

Ephedrine Sulphate. The sulphate of an alkaloid obtained from *Ephedra equisetina*. For a discussion of its actions and uses, see preceding abstract "Ephedrine."

Ephedrine Sulphate—Lilly. A brand of ephedrine sulphate—N. N. R. Ephedrine Sulphate—Lilly is also marketed in the form of Pulvules Ephedrine Sulphate—Lilly, 0.025 gm.; Pulvules Ephedrine Sulphate—Lilly, 0.05 gm.; Ampoules Ephedrine Sulphate—Lilly, 1 c.c., 0.05 Gm.; and Solution Ephedrine Sulphate—Lilly, 3 per cent. Eli Lilly & Co., Indianapolis. (Jour. A. M. A., March 19, 1927, p. 925).

Lactobacillus Acidophilus Milk (Towt). A milk culture of *B. acidophilus* which contains not less than 250 millions of viable organisms (*B. acidophilus*) per c.c. at the time of sale. For a discussion of the actions and uses of bacillus acidophilus preparations, see New and Nonofficial Remedies, 1926, p. 211, "Lactic Acid-Producing Organisms and Preparations." Towt-Nolan Laboratory, Oakland, Calif.

Scarlet Fever Streptococcus Toxin—Squibb (New and Nonofficial Remedies, 1926, p. 368). This product is also marketed in packages of three 1 c.c. vials, each containing 30,000 skin test doses. E. R. Squibb & Sons, New York.

Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., 0.05 gm., 1 c.c.; Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., 0.1 gm., 1 c.c.; Glaseptic Ampoules Sodium

Announcing

Burdick Portable Quartz Lamp

Features

1. Truly Portable. Can be taken down or set up in two minutes and can be easily carried.
2. Equipped with Uviarc Mercury Quartz Burner same as office models, volt meter, rheostat for controlling voltage and adjustable stand.
3. Adapted for operation on both Direct and Alternating currents. Arranged so that water cooled lamp can be added at any time.
4. Beauty in design, finish and workmanship.
5. Prices $365.75 net cash, or $385.00 on contract.
6. Can be used in office or home of patient.

SPECIAL RENTAL PLAN

Physicians may arrange to have a lamp installed in the home of a patient. Charge, including installation, with whatever service may be necessary, and removal, is $85.00 for three months and $25.00 each additional month thereafter, with option to purchase; sum paid as rental to apply on purchase price.

No lamps rented except on physician's prescription.

Description sent on request.

PENGELLY X-RAY COMPANY

220 LA SALLE BUILDING
MINNEAPOLIS, MINN.

PENGELLY X-RAY COMPANY — QUALITY SERVICE

14th & Wells Sts.
MILWAUKEE, WIS.

Cacodylate—P. D. & Co., 0.13 gm., 1 c.c.; Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., 0.2 gm., 1 c.c.; Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., 0.3 gm., 1 c.c.; Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., 0.45 gm., 1 c.c.; Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., 1 gm., 2 c.c.; Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., (for Intravenous Use), 0.2 gm., 5 c.c.; Glaseptic Ampoules Sodium Cacodylate—P. D. & Co., (for Intravenous Use), 0.45 gm., 5 c.c.; Glaseptic Ampoules Sodium Cacodylate—P. D. & Co. (for Intravenous Use), 1 gm., 10 c.c. For a discussion of the actions and uses of sodium cacodylate, see Useful Drugs, Seventh Edition, p. 133. Parke, Davis & Co., Detroit. (Jour. A. M. A., March 26, 1927, p. 1003.)

PROPAGANDA FOR REFORM

More Misbranded Nostrums. The following products have been the subject of prosecution by the federal authorities charged with the enforcement of the Food and Drugs Act: Ambrozoin Tablets (The American Apothecaries Co.), containing ammonium chloride, licorice extract, a calcium compound, traces of terpin hydrate and an iodide. Flam (Flam Co.), a flavored syrup containing ammonium chloride and bromide, with small amounts of sodium benzoate and glycerin. Lemke's Blood Drops and Laxative Herb Tea (Dr. H. C. Lemke Medicine Co.), the first consisting of extracts of plant drugs, including aloe, together with sugar, alcohol, and water; the second consisting of a mixture of powdered senna, with small portions of althea, fennel, buckthorn, elder, coriander, sassafras, flaxseed, lavender, American saffron, licorice, bear-berry, mullen, yarrow, boneset and peppermint. Bronchini (Wm. M. Chappelear & Sons Co.), consisting of ammonium chloride, extracts of plant drugs, flavoring material, including oils of anise, sassafras, sugar, alcohol and water. Arium Tablets (The Associated Radium Chemists, Inc.), composed mainly of lithium carbonate, starch and talc, with 8.58 millimicrograms of radium to each tablet. Moorite Mineral Powder (The Moorite Products Co.), consisting of powdered clay. (Jour. A. M. A., March 5, 1927, p. 744.)

Cardiazol. From German publications it appears that Cardiazol is claimed to be "Pentamethlentetrazol" and is one of a number of products which have been recently put out there that are claimed to produce the therapeutic effects of camphor. Cardiazol is a product of Knoll Aktiengesellschaft, Chemische Fabriken, Ludwigshafen a. Rh., Germany, marketed in the United States by E. Bilhuber, Inc., New York. Cardiazol has not been accepted for New and Nonofficial Remedies. (Jour. A. M. A., March 5, 1927, p. 747.)

Nitroscleran. Basler states that according to the manufacturer "Nitroscleran" has the following composition: Sodium chloride, 6.0; sodium nitrite, 20.0; or 40.0; sodium phosphate, 3.6; potassium phosphate, 2.0; water to make 1,000.0. The A. M. A. Chemical Laboratory reports that its tests were confirmatory of the statement of Basler that the preparation is nothing more than a solution of the well known sodium nitrite dissolved in water to which some salts have been added. (Jour. A. M. A., March 5, 1927, p. 747.)

Boric Acid and a Hospital Accident. In a hospital, through a confusion of technic among three nurses, infants in the nursery were apparently given boric acid solution instead of drinking water and six died. Such accidents will no doubt be prevented in the future by rulings relative to the manner of preparing water for drinking purposes and as to the bottling and labelling of all solutions of medicinal value. Compared with phenol, cresol or mercury preparations, boric acid is relatively nonpoisonous, but cases are recorded of death, even of adults, when considerable quantities of saturated boric acid solutions have been introduced into the body. In reported cases, from 1 to 3 gm. have produced serious symptoms, and from 15 to 30 gm. have been fatal to adults. In the recent accident, each baby must have received from 15 to 60 c.c. of a saturated solution of boric acid. (Jour. A. M. A., March 12, 1927, p. 841.)

Asthmolysin. According to the advertising, Asthmolysin is "a combination of the suprarenal and pituitary hormones in distinct proportions" which is prepared by a "special method." The use of pituitary in bronchial asthma is contraindicated. While epinephrine is used with advantage in some forms of asthma, there does not appear to be any reason why physicians should use a secret preparation containing an undetermined amount of it, when accuracy of dosage and therapeutic effectiveness may be obtained by the use of the pharmacopeial product. (Jour. A. M. A., March 12, 1927, p. 858.)

Ephedrine. The Council on Pharmacy and Chemistry reports that the A. M. A. Chemical Laboratory has found the ephedrine sulphate received from Eli Lilly & Co., to be of acceptable quality. The advertising claims for Ephedrine Sulphate—Lilly have been revised in accordance with the recommendations of the Council, and therefore the Council accepts Ephedrine Sulphate for description in New and Nonofficial Remedies and lists Ephedrine Sulphate—Lilly as a brand which complies with the New and Nonofficial Remedies' standards. (Jour. A. M. A. March 19, 1927, p. 924.)

The Lye Bill. Congress passed the Federal Caustic Poison Bill, March 2, and the President signed it on the following day. This requires that household packages of lye, ammonia, carbolic acid, oxalic acid, and other caustic substances named in the law be distinctly labelled "Poison," with instructions as to emergency treatment in case of accident. (Jour. A. M. A., March 19, 1927, p. 926.)

Parathyroid Extract and Lead Poisoning. Experiments have been made which indicate that parathyroid extract—Collip mobilizes from the bones a certain amount of stored lead which is readily available. Since the amounts of lead excreted following this treatment were far greater than those obtained in previous investigations, when ammonium chloride or phosphoric acid were given, the method will probably have some therapeutic value in the treatment of lead poisoning. (Jour. A. M. A., Feb. 19, 1927, p. 572.)

The Oritone Laboratories. "Oritone," an alleged aphrodisiac, sold by the Oritone Laboratories, Kansas City, Mo., has been declared a fraud by the Post Office authorities. Like many other nostrums that have, in

Formally Announcing

The New Keleket Diathermy Apparatus

In a scientific age, when rapid progress is being made through research and experiment, you want equipment that is typical of the latest and best. We introduce to you the new Keleket Diathermy Apparatus, with every confidence in its success.

It is equipped with the Keleket Resogap (name copyrighted—patent pending), which mutually varies the primary inductance with the amount of spark gap used in such a manner so as to bring about resonance of the total inductance and transferred condenser capacity at the power supply frequency. It is practically impossible to get faradic current regardless of operation.

The new Keleket Diathermy provides protection for the operator, has high voltage oil-immersed transformer, micrometric multiple spark gap control, selective gap control, duplex meter system, and low loss resonator.

The confidence of the profession, plus first-class materials and expert workmanship, are built into this new Diathermy, typical of Keleket for more than a quarter of a century.

See our representative in your territory, or write for the special bulletin.

THE KELLEY-KOETT MFG. CO., INC.

225 West Fourth Street

COVINGTON, KENTUCKY, U. S. A.

"The X-ray City"

Keleket

X-RAY EQUIPMENT

BRANCH OFFICES:

W. A. Bassett, Hotel Wisconsin, Milwaukee, Wis.

W. W. Mowry, 1152-54 Pure Oil Bldg., 35 E. Wacker Drive, Chicago, Ill.

The First Official showing of the new Keleket Diathermy Apparatus will be at the American Medical Association Convention in Washington, D. C., week of May 16.

the past, been sold by fraudulent medical mail-order concerns, Oritone, according to the government's report, was obtained from George A. Breon and Company, a concern that occasionally appeals to physicians in the pose of a reputable pharmaceutical house. The formula, according to the federal authorities, was: gaduol, 1 mm., thyroid substance, 1/12 gr., lecithin, 1/8 gr., suprarenal substance, 1/5 gr., extract nux vomica, 1/6 gr., pituitary substance, 1/24 gr., yohimbine hydrochloride, 1/12 gr. The evidence of the federal authorities showed that the use of the drugs contained in Oritone, either singly or in combination, will not and cannot relieve or cure "lost manhood" or rejuvenate the aged. (Jour. A. M. A., Feb. 19, 1927, p. 585.)

Medicago Sativa and Medicago Abrus Compound. According to the advertising of M. L. Howe, Indianapolis, each tablet of Medicago Sativa (Howes') is "equivalent to 120 gr.," presumably of Medicago Sativa. Each tablet of Medicago Abrus Compound is said to contain Abrus precatorius 2 gr. and Medicago Sativa 10 gr. In the price list, Medicago Sativa (Howes') is said to be "Tonic, Aphrodisiac, Diuretic, Galactagogue. Especially indicated in prostatic troubles, and cystitis, or any pus condition of the genito-urinary tract, including gonorrhea." The advertising states further that the firm has reports of its great benefit in diabetes. The firm further states that the combination contained in the Medicago Abrus Compound gives a remedy unsurpassed for diabetes. Medicago Sativa is a botanical name for the plant that yields alfalfa. Abrus precatorius is a name for Jambul seed. The value of "Medicago Sativa (Howes')" may be estimated by the following from a report of the Council on Pharmacy and Chemistry: "Alfalfa is a good cattle feed, but only nostrum exploiters have suggested its use as a medicine for human beings." Jambul was in vogue many years ago as a remedy for diabetes. It was tried, found wanting, and relegated to the therapeutic scrap heap. (Jour. A. M. A., Feb. 19, 1927, p. 588.)

Deterioration of Anesthetic Ether. According to the U. S. Pharmacopeia X: "Ether to be used for anesthesia must be preserved only in small, well closed containers, and is not to be used for this purpose, if the original container has been opened longer than twenty-four hours." The impurities found in ether are due to the presence of air and moisture, and the action of daylight, which leads to complex oxidations. Among the products found are hydrogen peroxide and most commonly irritant aldehyde. (Jour. A. M. A., Feb. 19, 1927, p. 588.)

Uselessness of Insulin by Inunction. Attempts to give insulin by mouth, perlingually, by duodenal tube, intratracheally, by inhalation, and by rectum, either in solution or in suppositories, have given results which in the main are either mechanically difficult, inconclusive, inconstant, or wasteful of the drug. An investigation has recently been made to decide whether insulin inunctions would be of any value in the treatment of human diabetes. As much as 1,000 units of insulin dissolved in almond oil was rubbed for a period of one hour into the skin of the abdomen, chest and arms with entirely negative results. Other vehicles were used with equally negative results. On the basis of this evidence the conclusion must be that insulin inunctions "are useless as a therapeutic measure." (Jour. A. M. A., Feb. 26, 1927, p. 652.)

Desitin Not Acceptable for N. N. R. The Council on Pharmacy and Chemistry reports that Desitin is the nondescriptive name applied to an ointment manufactured by the Chemische Fabrik Desitin Aktiengesellschaft, Berlin-Tempelhof, Germany, and distributed in the United States by the Desitin Chemical Company, Providence, R. I. According to the distributor, there are in 100 parts of Desitin, 28 parts zinc oxide, 14 parts "Bolus alba" (kaolin), 16 parts "Adeps lanae treated with H_3PO_4 and neutralized with KOH," 22 parts "Cod-liver oil extract, which is purified in a $KMnO_4$ solution and then extracted. This extraction is subjected to a treatment with Cl," and 20 parts "Natural Vaseline." No information was furnished the Council in regard to the actual composition of the cod liver oil extract and an analysis by the "Rijks-Instituut" did not confirm the claimed composition. The ointment is recommended for all sorts of skin lesions and extravagant claims are made for its effects. The Council found Desitin unacceptable for New and Nonofficial Remedies because the claims made for it are unwarranted. (Jour. A. M. A., Feb. 26, 1927, p. 666.)

Lukosine Not Acceptable for N. N. R. The Council on Pharmacy and Chemistry reports that "Lukosine" is an "antiseptic Vaginal Douche Powder" manufactured by The National Drug Co., Philadelphia. In the advertising, the preparation is said to contain "the valuable antiseptic constituents of Thyme, Peppermint, Eucalyptus, Wintergreen with Boric Acid, Alum, Zinc Sulphate, Hydrastine Hydrochloride, Sodium Salicylate and Phenol." Extravagant claims for the efficiency of Lukosine in the treatment of Leucorrhea and other conditions are contained in the advertising. Preparations similar to Lukosine have been offered to the medical profession and to the public for many years. The Council found Lukosine unacceptable for New and Nonofficial Remedies because it is a semi-secret, needlessly complex, and therefore irrational, mixture, marketed with a therapeutically suggestive name and with unwarranted claims, in such a way as to lead to its indiscriminate and ill-advised use by the public. (Jour. A. M. A., Feb. 26, 1927, p. 667.)

The Campaign Against Nostrums in Central America. A Nicaraguan pharmaceutic journal refers to the efforts made in Nicaragua to protect the public against nostrum exploitation, pointing out that such products are manufactured in the U. S. only for exportation, their use being forbidden at home. The blame is placed on American "manufacturing houses which take advantage of the lack of protecting laws as well as the unscrupulousness of dealers." The protest is accompanied by the publication of the names of forty preparations whose sale has been recently forbidden in Guatemala. (Jour. A. M. A., Oct. 16, 1926, p. 1307.)

The "Goldsmiths"

THE history of securities is closely allied to the activities of the "Goldsmiths" of old. These "Goldsmiths" in Italy, Spain, France or England were skilled craftsmen in gold and silver and as dealers in precious metals soon became the bankers of their day.

AS business grew and foreign trade expanded, it became necessary to produce a portable type of currency and investment. Early in the Fifteenth Century the first securities came into being in the form of government obligations to the Goldsmiths.

THE "Goldsmith" of long ago has been supplanted by the bond house and modern bank of today. Anyone with as little as $100 can invest in bonds as easily as he can buy his next winter's overcoat.

WE maintain at all times a list of sound securities, including a selection of public utility, municipal, railroad, real estate, industrial and foreign bonds, thus supporting our slogan—
"A Bond for Every Buyer".

Second Ward Securities Co.

Milwaukee ... Chicago

THERAPEUTIC NOTES

New and Nonofficial Remedies

In addition to the articles enumerated previously, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories

Tablets Triturates Ephedrine Hydrochloride—Abbott, ½ grain.

Capsules Ephedrine Hydrochloride—Abbott, ¾ grain.

Ephedrine Hydrochloride Solution—Abbott, 3%.

Parke, Davis & Co.

Glaseptic Ampoules Mercury Salicylate—P. D. & Co., 0.065 Gm. (1 grain).

Glaseptic Ampoules Mercury Salicylate—P. D. & Co., 0.13 Gm. (2 grains).

Glaseptic Ampoules Mercury Succinimide—P. D. & Co., 0.01 Gm. (1/6 grain).

Sigurd E. Roll

Viking Palatable Cod Liver Oil.

Swan-Myers Co.

Ephedrine Hydrochloride—Swan-Myers.

Capsules Ephedrine Hydrochloride — Swan - Myers, 0.0324 Gm. (½ grain).

United States Standard Products Co.

Rabies Vaccine—U. S. S. P. (Semple Method).

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

Culture Bacillus Acidophilus—United Laboratories.—A pure culture of *B. acidophilus* in bottles each containing about 120 c.c. It contains not less than six hundred millions of viable organisms *(B. acidophilus)* per c.c. at the time for sale. For a discussion of the actions and uses of bacillus acidophilus preparations, see New and Nonofficial Remedies, 1926, p. 211, "Lactic Acid-Producing Organisms and Preparations." United Laboratories, Inc., Pasadena, Calif. (Jour. A.M.A. April 9, 1927, p. 1150.)

Abbott's Mineral Oil Emulsion.—A mixture composed of liquid petrolatum, 40 c.c.; agar, tragacanth and gelatin, 2 Gm.; sugar and flavoring, 2 Gm., and water sufficient to make 100 c.c. It has the action of liquid petrolatum. Abbott Laboratories, North Chicago, Ill.

Ephedrine Hydrochloride—Swan-Myers.—A brand of ephedrine hydrochloride—N. N. R. For a discussion of the actions, uses and dosage of ephedrine hydrochloride, see THE JOURNAL, A.M.A. March 19, 1927, p. 925. The product is marketed in substance and as Capsules Ephedrine Hydrochloride—Swan-Myers, 0.0324 Gm. (½ grain). Swan-Myers Company, Indianapolis.

Ephedrine Hydrochloride — Abbott. — This product (THE JOURNAL, A.M.A. March 19, 1927, p. 925) is also supplied in the form of Tablet Triturates Ephedrine Hydrochloride-Abbott, ½ grain, Capsules Ephedrine Hydrochloride-Abbott, ¾ grain and Ephedrine Hydrochloride Solution-Abbott, 3%, Abbott Laboratories, North Chicago, Ill. (Jour. A.M.A. April 16, 1927, p. 1235.)

Glaseptic Ampoules Mercury Salicylate—P. D. & Co., 0.065 Gm. (1 grain).—Each c.c. contains mercuric salicylate (New and Nonofficial Remedies, 1926, p. 247) 0.13 Gm.; apothesine, 0.01 Gm.; in olive oil, 1 c.c. Parke, Davis & Co., Detroit.

Glaseptic Ampoules Mercury Salicylate—P. D. & Co., 0.13 Gm. (2 grains).—Each c.c. contains mercuric salicylate (New and Nonofficial Remedies, 1926, p. 247) 0.065 Gm.; apothesine, 0.01 Gm.; in olive oil, 1 c.c. Parke, Davis & Co., Detroit.

Glaseptic Ampoules Mercury Succinimide—P. D. & Co., 0.01 Gm. (1/6 grain).—Each c.c. contains mercuric succinimide—N .N. R. (New and Nonofficial Remedies, 1926, p. 248) 0.01 Gm.; apothesine, 0.005 Gm.; in physiological solution of sodium chloride, 1 c.c. Parke, Davis & Co., Detroit. (Jour. A.M.A. April 30, 1927, p. 1398.)

PROPAGANDA FOR REFORM

The Prevention of Measles.—The need for a specific treatment of measles is evident. However, no effective measures for use after onset of the attack have been thus far developed, although methods of measles prophylaxis have been demonstrated. The efficacy of the blood serum of convalescent measles cases in preventing the disease has been established. The convalescent serum must be administered subcutaneously or intramuscularly as soon as possible after contact, the degree of protection afforded depending on the promptness with which the serum is given. Some workers advocate the use of the blood of adults or of children who have had the disease some years previously when recent convalescents are not available. The difficulty of securing a constant supply of convalescent measles serum is the chief obstacle to its wide use. Favorable results have been reported from the use of an immune goat serum. If confirmed, this may obviate dependence on a human supply. Good results have also been reported with a serum made from blood of sheep inoculated with the Berkefield filtrate of the nasal secretion and sputum of measles patients. Attempts at active immunization by the use of blood of measles patients at the onset of the eruption have been made. These reports are interesting, but longer observation will be required before their worth can be estimated. In the treatment of established measles, the great desideratum is an effective method of preventing the dangerous secondary infections. (Jour. A.M.A. April 2, 1927, p. 1081.)

Arc and Mercury Vapor Lamps.—The carbon arc and quartz mercury arc lamps are generators of ultraviolet energy. The carbon arc lamp delivers about 5 per cent of its total spectral energy in the ultraviolet zone, and the quartz mercury arc lamp delivers about 28 per cent. An erythema dose can be readily obtained with a mercury arc but it requires a considerable exposure in the case of a carbon arc. Some believe that an erythema is necessary, whereas others believe that an erythema is unnecessary, to good clinical results. (Jour. A.M.A. April 2, 1927, p. 1102.)

More Misbranded Nostrums.—The following products have been the subject of prosecution by the federal authorities charged with the enforcement of the Food and Drugs Act: Tonica Para Los Nervois (Henry S. Wampole Co.), containing calcium, sodium, potassium and strychnine glycero-phosphates, a trace of lecithin, sugar, alcohol and water. Boro-Pheno-Forum (Dr. Pierre Chemical Co.)

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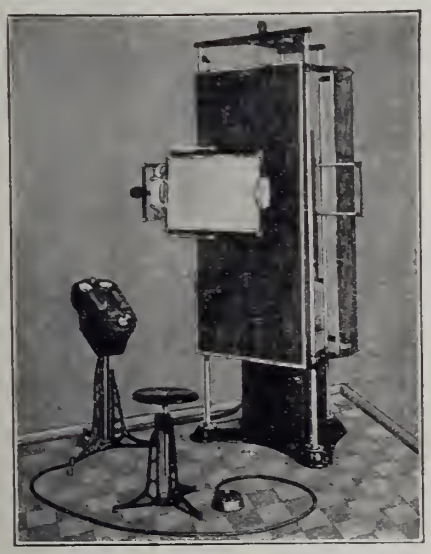

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suppositories containing cocoa butter, quinine sulphate, zinc sulphate, boric acid and traces of formaldehyde and carbolic acid. Whitlock's Specific (The Cherokee Remedy Co.), consisting of approximately 99 per cent of water with small amounts of alum, sodium benzoate and extract of a plant drug. Bailey's Nu-Life (The Tex Bailey Corporation), consisting essentially of a watery solution of epsom salt, iron chloride, salicylic acid, with red pepper and senna, flavored with sassafras and sweetened with saccharine. (Jour. A.M.A. April 9, 1927, p. 1197.)

Rice Rupture Cure.—Wm. S. Rice, Inc., Adams, N. Y., sells what the public is led to believe is a cure for rupture. The concern sometimes advertises under its own name and address and sometimes under the name of a stool-pigeon, one Eugene M. Pullen, Manasquan, N. J. The Rice concern, in common with most mailorder rupture cures, decries the use of the truss and gives the impression that what they have to sell is something entirely different. However, the device is essentially a band of webbing with a pad and understrap. Like most mailorder "rupture cures," the Rice device has a "patent medicine" adjunct—"Developing Lymphol." It is claimed, either inferentially or directly, that Lymphol will repair the break in the abdominal wall and thus permanently cure the rupture. Lymphol was analyzed and found to be an alcoholic solution containing essential oils, capsicum and resin, colored red. (Jour. A.M.A. April 9, 1927, p. 1199.)

The Assimilation of Iron.—Investigations have been published, which the investigators believe to indicate that vitamin E is a substance specifically related to iron assimilation in a manner comparable to the relation of vitamin D to phosphorus and calcium metabolism. On this basis the use of ferric citrate and a fat having the properties of wheat germ oil—a potent source of vitamin E—is suggested as a logical basis for the treatment of secondary anemias. Since liver is rich in iron and in vitamin E this may be an explanation for the reported value of liver in the treatment of pernicious anemia. (Jour. A.M.A. April 23, 1927, p. 1323.)

The Scarlet Fever Patents.—The Scarlet Fever Committee, established to control the use of the methods resulting from the discoveries of the Drs. Dick relating to scarlet fever, has thought it advisable to secure in Great Britain patents similar to those sought in this country for the protection of the manufacture and use of the methods and products. In view of alarm expressed in British medical publications, the Drs. Dick explain that they sought the most competent advice before embarking on the procedure. They reveal that they have not had and will not receive compensation personally from the patents; they have sought only to prevent the manufacture and sale of unworthy or inefficacious products in order that the public might be protected against commercial exploitation. (Jour. A.M.A. April 23, 1927, p. 1324.)

The Creoco Remedy Co.—D. H. Brown, M.D., of Jacksonville and St. Augustine, Fla., is a negro quack who for years has been swindling consumptives. This man's particular piece of quackery has in the past gone under the name "Dr. Brown's New Consumption Remedy" and he made his appeal especially to those unfortunate members of his own race who were afflicted with tuberculosis. More than ten years ago Brown was prosecuted under the Federal Food and Drugs Act because he was crude enough to make claims on the trade package of his nostrum to the effect that it was a remedy for consumption, pneumonia, and all diseases of the lungs. Subsequently Brown ceased making fraudulent claims on the trade package, but continued to sell his worthless nostrum, making the same false and fraudulent claims in newspaper advertisements and circulars. In 1923 a fraud order was issued by the Post Office Department against D. H. Brown and his concern known as the Magnolia Remedy Co. Then Brown attempted to continue the business by creating the Creoco Remedy Co., selling the same preparation under the name of this company, and calling the preparation "Creoco." Now a supplemental fraud order against the Creoco Remedy Co. has been issued. (Jour. A.M.A. April 23, 1927, p. 1340.)

International Health Institute.—During the past few months the medical profession has been flooded with letters from the "International Health Institute, Inc.," 2061 Broadway, New York City. According to its "sales talk," the International Health Institute purposes to sell to the public a urinalysis and periodic physical examination service "supplemented with a complete course in body-building and rules of right living." While this is the nominal *raison d'etre* of the concern, evidence is accumulating to confirm the suspicion that the International Health Institute, Inc., is primarily a promotion scheme. Letters are sent to physicians stating that the "Institute" desires to establish "a resident physician and member of our Advisory and Hygiene Reference Board;" invites the physician to join and to purchase stock. It is stated that the first source of income is the service that is to be recommended by the International Health Institute in selling to the public a periodic physical examination and urinalysis, for which the institute will charge $37.50, but it is explained that a greater opportunity for financial betterment will come from the activities of the International Health Institute in recommending to the lay subscribers that they use certain health foods; certain "approved exercising devices;" certain "hygienic appliances;" and certain books, all of which the institute will sell. (Jour. A.M.A. April 30, 1927, p. 1435.)

"Iodex" in Thyroid Disturbances.—A pamphlet published by the Pharmacal Advance Press, the house organ of Menley and James, Ltd., the firm that sells Iodex, is devoted to promoting the use of iodex ointment in the treatment of systemic goiter by rubbing ointment into the skin over the thyroid gland twice a day, and also recommending iodex ointment for a number of other pathologic conditions. The Council on Pharmacy and Chemistry has reported that the preparation was practically devoid of free iodine, that its composition was incorrectly stated, that the total iodine content was only about three-fifths of the total amount of iodine claimed, and that therefore its use for securing iodine effects is unwarranted. Almost any intelligent physician knows that the attempt to treat systemic goiter by rubbing such an ointment into the skin over the goiter is preposterous. However, this is but one of many ridiculous statements in the pamphlet mentioned. (Jour. A.M.A. April 30, 1927, p. 1438.)

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THERAPEUTIC NOTES

New and Nonofficial Remedies

In addition to the articles enumerated, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories
- Neonal.

Certified Laboratory Products
- Ethylene—C. L. P.

Cutter Laboratory
- Alkali Weed Pollen Extract—Cutter.
- All Scale Pollen Extract—Cutter.
- Box Elder Pollen Extract—Cutter.
- Burning Bush Pollen Extract—Cutter.
- Corn Pollen Extract—Cutter.
- Foxtail Pollen Extract—Cutter.
- Mountain Cedar Pollen Extract—Cutter.
- Tumbleweed Pollen Extract—Cutter.
- Western Water Hemp Pollen Extract—Cutter.

Fairchild Bros. & Foster
- B. Acidophilus Milk—Fairchild.

Horlick's Malted Milk Corporation
- Horlick's Maltose-Dextrin Milk Modifier.

H. K. Mulford Co.
- Lamb's Quarters Pollen Extract (Glycero-Saline)—Mulford.
- Ragweed Pollen Extract (Glycero-Saline)—Mulford.
- Timothy Pollen Extract (Glycero-Saline)—Mulford.
- Wormwood Pollen Extract (Glycero-Saline)—Mulford.

Parke, Davis & Co.
- Alfalfa Pollen Protein Extract Diagnostic—P. D. & Co.
- Kidney Bean Protein Extract—P. D. & Co.
- Typhoid Vaccine (Prophylactic).
- Typhoid-Paratyphoid Vaccine (Prophylactic).

E. R. Squibb & Sons
- Ovarian Hormone—Squibb.

Swan-Myers Co.
- Ampoules Ephedrine Hydrochloride—Swan-Myers, 0.05 Gm., 1 cc.
- Capsules Ephedrine Hydrochloride—Swan-Myers, 0.025 Gm.
- Solution Ephedrine Hydrochloride—Swan-Myers, 3%.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

Viking Palatable Cod Liver Oil.—Cod liver oil containing 0.2 per cent of benzaldehyde. Its fat soluble vitamin A content is such that 0.002 Gm. per day is sufficient to initiate growth in the albino rat. Sigurd E. Roll, Chicago.

Rabies Vaccine—U. S. S. P. (Semple Method).—An antirabic vaccine (New and Nonofficial Remedies, 1927, p. 347) prepared according to the general method of David Semple (phenol killed). Marketed in packages of fourteen syringes, each containing 3 cc. The content of a syringe is administered daily over a period of fourteen days. United States Standard Products Co., Woodworth, Wis. (Jour. A. M. A. May 21, 1927, p. 1637.)

Ampoules Ephedrine Hydrochloride—Swan-Myers, 0.05 Gm., 1 cc.—Each ampoule contains 0.05 Gm. of Ephedrine Hydrochloride—Swan-Myers (Jour. A. M. A., April 16, 1927, p. 1235) in 1 cc. Swan-Myers Co., Indianapolis.

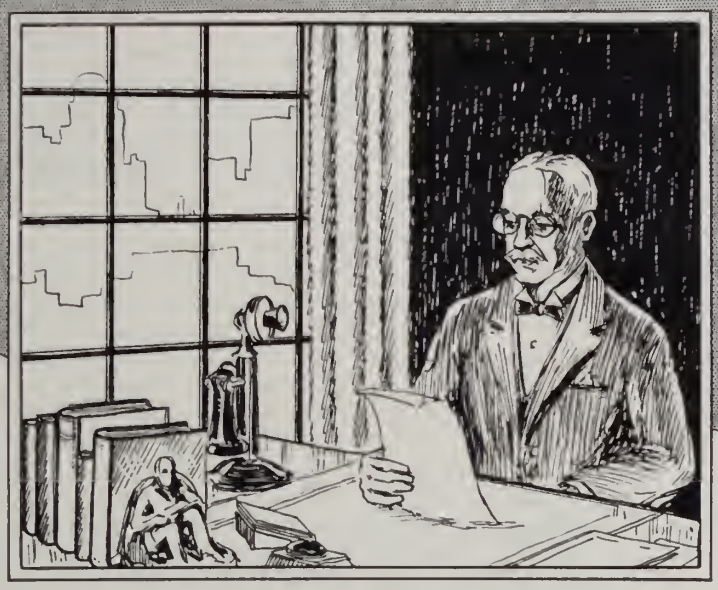
Capsules Ephedrine Hydrochloride—Swan-Myers, 0.025 Gm.—Each capsule contains 0.025 Gm. of Ephedrine Hydrochloride—Swan-Myers (Jour. A. M. A., April 16, 1927, p. 1235). Swan-Myers Co., Indianapolis.

Solution Ephedrine Hydrochloride—Swan-Myers, 3%. —A 3 per cent solution of Ephedrine Hydrochloride—Swan-Myers (Jour. A. M. A., April 16, 1927, p. 1235), preserved with chlorbutanol 0.5 per cent. Swan-Myers Co., Indianapolis.

Ovarian Hormone—Squibb.—A sterile, aqueous solution representing the physiologically active principle of the whole ovary. It is standardized in terms of its effect on spayed albino rats, one rat unit being the quantity necessary to induce estrus as judged by the smear method within three days in an ovariectomized, sexually mature rat weighing approximately 140 Gm. Ovarian hormone—Squibb is administered by hypodermic injection. For recent cases of amenorrhea, artificial or natural menopause, from 50 to 100 units is given in a series of injections over a period of from three to five days. For long existing cases of amenorrhea, artificial or natural menopause, much larger doses may be administered. Ovarian Hormone—Squibb is supplied in 5 cc. vials, each cubic centimeter representing 10 units. E. R. Squibb & Sons, New York. (Jour. A. M. A., May 28, 1927, p. 1713.)

PROPAGANDA FOR REFORM

Injection Treatment of Varicose Veins.—In the face of growing enthusiasm for the treatment by injection of varicose veins of the leg and hemorrhoids, it is well to consider a recent report of a death after injection treatment of varicose veins. A man, aged 60, who had dilated veins of the left leg, was treated at short intervals with five injections of a 20 per cent sodium chloride solution Serious symptoms developed, but the patient overcame these. However, about one month after the injection treatment he died suddenly of embolism of the pulmonary artery. One case proves nothing, but one disaster is an indication for caution. (Jour. A. M. A., May 14, 1927, p 1571.)



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clusive); fourth series (doses 16 to 20, inclusive). The following preparations have been accepted: Lamb's Quarters Pollen Extract (Clycero-Saline)—Mulford; Ragweed Pollen Extract (Glycero-Saline)—Mulford; Timothy Pollen Extract (Glycero-Saline)—Mulford; Wormwood Pollen Extract (Glycero-Saline)—Mulford. H. K. Mulford Co., Philadelphia. (Jour. A. M. A., June 11, 1927, p. 1891.)

Ethylene—C. L. P.—A brand of ethylene for anesthesia—N. N. R. For a discussion of the actions and uses see New and Nonofficial Remedies, 1927, p. 50. Certified Laboratory Products, Glendale, Calif.

Protein Extracts Diagnostic—P. D. & Co.—In addition to the products listed in New and Nonofficial Remedies, 1927, p. 40, the following have been accepted: Alfalfa Pollen Protein Extract Diagnostic—P. D. & Co.; Bean (Kidney) Protein Extract Diagnostic—P. D. & Co. Parke, Davis & Co., Detroit.

Typhoid Vaccine (Prophylactic) (New and Nonofficial Remedies, 1927, p. 369).—This product is also marketed in packages of one 20 cc. vial containing 1,000 million killed typhoid bacilli per cc. Parke, Davis & Co., Detroit.

Typhoid-Paratyphoid Vaccine (Prophylactic) (New and Nonofficial Remedies, 1927, p. 369).—This product is also marketed in packages of one 20 cc. vial containing 1,000 million killed typhoid bacilli and 750 million each of killed paratyphoid bacilli A and B per cc. Parke, Davis & Co., Detroit.

Horlick's Maltose—Dextrin Milk Modifier.—A mixture containing approximately: maltose, 63 per cent; dextrin, 19.5 per cent; protein, 11.5 per cent; fat, 1.4 per cent; moisture, 2 per cent; and ash, 2.6 per cent. On the claim that maltose is more readily assimilable than other forms of sugar, this product is proposed to supplement the carbohydrate of cow's milk. Horlick's Malted Milk Corporation, Racine, Wis. (Jour. A. M. A., June 18, 1927, p. 1967.)

B. Acidophilus Milk—Fairchild.—A whole milk cultured with *B. acidophilus*. It contains not less than 50 millions of viable organisms (*B. acidophilus*) per cc. at the time of sale. For a discussion of the actions and uses of bacillus acidophilus preparations, see New and Nonofficial Remedies, 1927, p. 216, "Lactic Acid-Producing Organisms and Preparations". Fairchild Bros. & Foster, New York. (Jour. A. M. A., June 25, 1927, p. 2035.)

PROPAGANDA FOR REFORM

The Origin of Vitamin D.—The antirachitic substance, vitamin D, occurs in some fish oils—notably in cod liver oil, in egg yolk fat, and to a small extent in milk fat. As a rule the vegetable fats are not antirachitic. A few instances of undoubted potency in oils of plant origin have been ascribed to the effect of solar irradiation of the products incident to their commercial preparation. This is true of coconut oil prepared from sun-dried copra. Whereas the other vitamins appear to originate in the vegetable kingdom, this is not the case with vitamin D. Experiments carried out to learn the origin of vitamin D in the codfish raise the question as to whether vitamin D cannot actually be synthesized by certain species. These experiments also revealed that the oils of the herring and sardine rival the cod in antirachitic potency. (Jour. A. M. A., June 4, 1927, p. 1807.)

The "Cass Treatment" Trickery.—The "Cass Treatment for Rheumatism" was a particularly bold piece of Chicago mail-order quackery, conducted under the name "Cass Laboratories". The Cass Laboratories were not laboratories; its alleged president, "Harvey L. Cass", who was featured throughout the advertising, did not exist, but the concern was run by one H. L. Cassel in association with his brother-in-law, one Joseph V. Creevy. The "treatment" consisted of baking soda tablets, of other tablets containing aspirin and cinchophen, and of some flavored epsom salt, as was shown by an analysis made by the A. M. A. Chemical Laboratory. In October, 1926, the Post Office Department called on the Cass Laboratories to show cause why a fraud order should not be issued against it. In February, 1927, Cassel submitted an affidavit to the Post Office Department, declaring that he was authorized and empowered to execute it on behalf of the Cass Laboratories, and swearing: "That the business heretofore conducted under the name Cass Laboratories has been discontinued and abandoned and will not be resumed at any time in the future." The facts were that for a month or more before Cassel made this sworn statement the name "Cass Laboratories" had been abandoned and the rheumatic public was receiving the same line of quackery under a new trade name: "H. L. Cass Corporation". It is to be hoped that in due time the post office authorities will issue a fraud order not only against the company itself, but against those conducting it. (Jour. A. M. A., June 18, 1927, p. 1983).

Prodigaluz, a Spanish Nostrum Sold to Gullible Americans.—A nostrum for the alleged cure of all diseases of the eye has been exploited during the past year in some American newspapers and magazines under the name of "Prodigaluz". The preparation was claimed to be a general specific for diseases of the eye and to cure trachoma, ulcerations of the cornea, cataracts, gonorrheal conjunctivitis, progressive myopia, etc. The federal authorities reported the preparation to be a slightly turbid liquid, having a wine-like odor, and containing alcohol, potash, zinc sulphate and tannin. The Post Office Department issued a fraud order which will prevent the exploitation of this nostrum through the mails. (Jour. A. M. A., June 4, 1927, p. 1831.)

Kerosene.—Kerosene is a weak antiseptic and parasiticide and irritant to the skin. Therefore: It can be used for parasitic affections of the scalp. It is of some use for seborrheic dermatitis of the scalp and, if it has any effect in preventing the outfall of hair, it is presumably due to its irritating—stimulating—effect on the skin. But it does all these things in a crude, disagreeable way. All of them can be done more efficiently and much more accurately with drugs of definite composition. Its vogue as a hair tonic and hair restorer is largely due to that popular feeling, which has come down through the milleniums from our barbarous ancestors, that the efficiency of drugs is in proportion to their disagreeableness. (Jour. A. M. A., June 25, 1927, p. 2048.)

THE WISCONSIN MEDICAL JOURNAL

STATE MEDICAL SOCIETY OF WISCONSIN — MEDICINA NUSQUAM NON EST

Owned and Published by the State Medical Society of Wisconsin

J. G. CROWNHART, Secretary-Managing Editor

VOLUME XXVI
NUMBER 1

MILWAUKEE, WIS., JANUARY, 1927

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PREMIUM ON BREVITY

MEDICAL journalism and the conscientious readers of medical journals suffer tremendously from the prolixity of the confirmed medical essayists. The more lazy minded doctors don't suffer. They just don't read medical literature and then the people who employ such doctors do the suffering. Our journals and our medical society meetings would be far more interesting, practical and valuable (and would consume far less time) if we could put a premium on *brevity* and a heavy handicap on *ponderosity*. But we doctors seem to go about it the other way.

We'd do well to copy our literary style from the advertising pages of the magazines which charge several thousand dollars a page for space. The writers of such advertising get paid for the words they save rather than for the ones they use.—H. E. D.

(Table of Contents, Page IV.)

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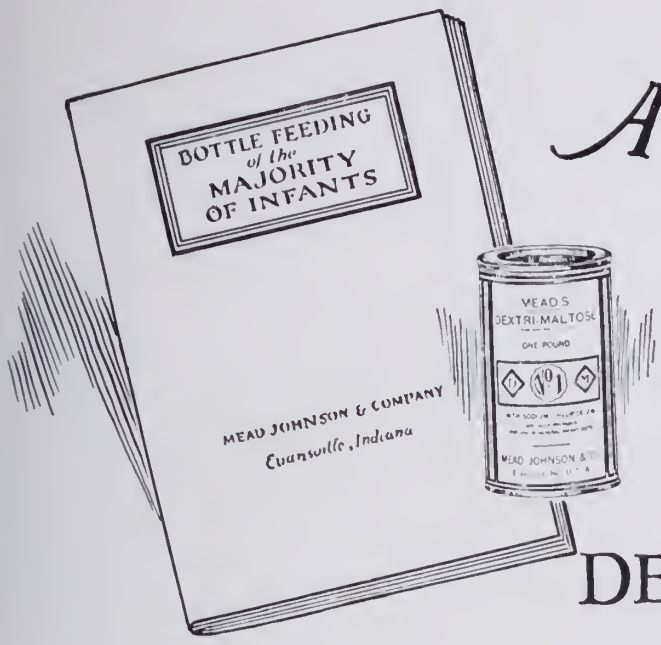

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The reasons why Mead's Dextri-Maltose has gained its reputation for dependability are also shown. Some of the items of Mead's infant feeding service are described in detail and we believe they will interest the physician for they offer a number of time-saving conveniences.

CONTENTS

The Feeding of Well Babies

Mead's Dextri-Maltose

Certain Types of Sick Infants

Casec, with Cow's Milk and Water
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Non-Thriving Breast-Fed Babies
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A PROPHET

"The moral, the humane physician should stop" with the attempt merely to assist "the salutary effort which nature makes to re-establish the disordered functions."

Those are not the words of a modern teacher of medicine and therapeutics but a personal theory of Thomas Jefferson, quoted by Albert Jay Nock in his recent book on our third president. Contrast that theory with the well known practices of the physicians of his day. Recall also his foresightedness in being one of the first to accept "innoculation for the small pox" and his letter to Jenner in which he made a prediction not yet fulfilled, but now known to be absolutely possible: "future nations will know by history that the loathsome small pox has existed and by you has been extirpated."

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Yet however appealing the theory of a combination of Dextrin and Maltose as a carbohydrate might have been, its actual value is determined by practical results alone.

Experience has proven its Dependability!

Its uniformity of composition, ease of assimilation, flexibility of use in difficult cases and its greater tolerance by the majority of infants are a few of the ever constant factors contributing to its increasing use in the clinic and in private practice.

Keeping well babies well is not its only claim for favor. The fact that it can usually be given sooner and in larger amounts than any other sugar after an attack of fermentative diarrhoea is added assurance of dependability when used in normal infants.

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PERIODIC HEALTH EXAMINATIONS

As an analogy to human existence, we may point to certain old elms standing in the public squares in some of our eastern communities. Their defects have long been kept remedied by caretakers and they have outlived all their fellows. They still stand sturdy with the passing of the years. They point the way to individuals to take example thereby in the hopes of meeting to a full extent the years to which they are entitled.

—Wisconsin State Board of Health.

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How high protein feedings with carbohydrate additions can be used to correct fermentative (summer) diarrhoea

Mead's Casec
(Calcium Caseinate)

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The correction of fermentative diarrhoea is accomplished by the control of the bacterial activity in the intestines which produces the disturbance.

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A rational way to combat the excess activity of acid-forming bacteria is temporarily to reduce the carbohydrate and increase the amount of protein in the feeding. This may be done by adding Casec to diluted cow's milk. The administration of this mixture usually produces less frequent stools and of a paste-like consistency within one or two days.

After two or three days of such feedings, Mead's Dextri-Maltose is the form of carbohydrate usually added gradually to the feedings to prevent carbohydrate starvation. Mead's Dextri-Maltose is the carbohydrate most easily assimilated, having greater limits of tolerance in infants recovering from fermentative diarrhoea.

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TO THE MEDICAL PROFESSION

"It is to the medical profession in its broadest sense, untrammeled by the contentions of different schools, that the world may look for large contributions toward its regeneration, physically, mentally and spiritually, when not force but reason will hold universal sway. As human beings gain in individual perfection, so the world will gain in social perfection, and we may hope to come into an era of right living and right thinking, of good will and of peace, in accordance with the teachings of the Great Physician."

—*Calvin Coolidge, President of the United States, Address to the American Medical Association, 1927.*

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YOUR SOCIETY

The well-conducted medical society should represent a clearing house, in which every physician of the district would receive his intellectual rating, and in which he could find out his professional assets and liabilities. We doctors do not "take stock" often enough, and are very apt to carry on our shelves stale, out-of-date goods. The society helps to keep a man "up to the times," and enables him to refurnish his mental shop with the latest wares. Rightly used, it may be a touchstone to which he can bring his experiences to the test and save him from falling into the rut of a few sequences. It keeps his mind open and receptive, and counteracts that tendency to premature senility which is apt to overtake a man who lives in a routine."

—Osler, "Aequanimitas."

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There is a term in economics singularly applicable to Mead's Dextri-Maltose—*marginal utility.*

Economically speaking it means those particular groups which constitute the margins—groups which, for one reason or another, cannot utilize a given product. In infant feeding there are also marginal groups.

The marginal utility of Mead's Dextri-Maltose is not to be reckoned solely by the majority of normal infants, for which it provides an acceptable carbohydrate. Rather its marginal utility should be considered *from the point—or border line—beyond which it can be successfully used after other carbohvdrates fail.*

Or, in other words, from the innumerable infant feeding cases in which it has eliminated further nutritional disturbances when intolerance for other sugars was acquired.

And again—from the increased amount over other sugars that can be fed, with greater safety, when normal digestion has been restored.

Samples and Literature on Request.

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VOLUME XXVI
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AT THIS TIME

One year ago there appeared on this cover a statement by Osler which we believe is worth annual repetition. In his lecture on the educational value of the medical society, presented at New Haven in 1903, Osler said:

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A CHANGE

"Of late years we physicians have been increasingly reminded, through the press, by laymen, and even by some of our colleagues, of things of which we are remotely conscious; namely, that the profession of medicine is undergoing a change; that there is a 'wind blowing,' and even the word 'revolution' has been used. We live in an age, and in a country in particular, where changes take place so rapidly that a luxury of today becomes a necessity tomorrow. And it is possible that we as busy practitioners are not sufficiently cognizant of these changes."

—President's Address, A. W. Rogers, in this Issue.

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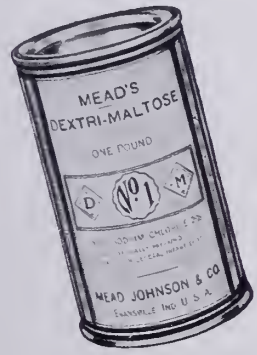

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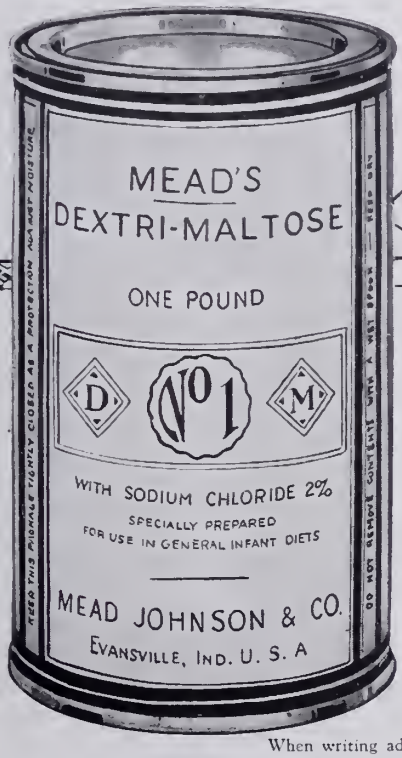

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